

## Adverse Childhood Experiences and Mental Health in Women: Pathways of Influence in a Clinical Sample

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### Abstract

**Background:** While the negative impacts of Adverse Childhood Experiences (ACEs) on mental health have already been established in previous research, the pathways through which these events affect psychological well-being are still unclear. This cross-sectional study analyzed the relationship between ACEs and psychological distress. It also examined the role of coping strategies, emotion regulation, and adult attachment in this association. **Method:** The sample consisted of 207 women receiving psychotherapeutic support from Public Mental Health Services in Spain. Just under half (46.4%) being treated by clinical psychology services and just over half (53.1%) were also being treated by psychiatry services. Descriptive and association analysis were performed on the variables involved. **Results:** 48.3% of participants reported four or more ACEs and the correlation with symptom severity was significant. Regression equations showed that four variables explained 56.2% of the variance: Fear of Rejection and Abandonment, Lack of Control, Rejection and Cognitive Restructuring. **Conclusions:** ACEs are directly associated with the severity of psychological distress. The data suggest that appropriate, sensitive exploration of these experiences can be therapeutic. The relationships between type of adversity, attachment relationships, emotion regulation, and coping strategies reveal indirect pathways through which ACEs affect women's mental health.

**Keywords:** Adverse childhood experiences, mental health, emotional regulation, coping strategies, attachment.

### Resumen

**Experiencias Adversas en la Infancia y Salud Mental en Mujeres: Vías de Influencia en una Muestra Clínica. Antecedentes:** aunque el impacto negativo de las Experiencias Adversas Infantiles (ACEs) en la salud mental ha sido constatado en investigaciones previas, las vías a través de las que afectan al bienestar psicológico no están claras. Este estudio transversal analizó la relación entre ACEs y presencia de disfunciones psíquicas y el papel de las estrategias de afrontamiento, la regulación emocional y el apego adulto en esta asociación. **Método:** formaron la muestra 207 mujeres que recibieron apoyo psicoterapéutico en los Servicios Públicos de Salud Mental en España. El 53,1% también fueron atendidas por psiquiatría. Se realizaron análisis descriptivos y asociativos de las variables implicadas. **Resultados:** el 48,3% informó de 4 o más ACEs, la correlación con la severidad de los síntomas fue significativa. Las ecuaciones de regresión mostraron que cuatro variables explicaban el 56,2% de la varianza: Miedo al Rechazo y Abandono, Descontrol, Rechazo y Reestructuración Cognitiva. **Conclusiones:** las ACEs están directamente asociadas con la gravedad de las disfunciones psíquicas. Estos datos sugieren que una adecuada exploración sensible a estas experiencias puede ser terapéutica. La relación entre tipo de adversidad y las variables estudiadas muestra vías indirectas a través de las cuales las ACEs afectan a la salud mental de las mujeres.

**Palabras clave:** experiencias adversas infantiles, salud mental, regulación emocional, habilidades de afrontamiento, apego.

There is a growing body of research pointing to the long-term impact of adverse childhood experiences (ACEs) on people's physical and mental health (Felitti et al., 1998; Johnson et al., 2020; Larkin et al., 2012; Petruccioli et al., 2019). Nevertheless, identifying the variables that increase an individual's likelihood of developing mental disorders continues to be a challenge. Although the literature has established the relationship between ACEs and the frequency and degree of long-term psychological distress, few studies have addressed their presence and the

pathways through which they affect mental health service users in Spain.

Interest in ACEs has been growing ever since the publication of the *Adverse Childhood Experiences Study* (Felitti et al., 1998). This investigation revealed the frequency of these experiences, their long-term consequences, and the graded association between exposure to adversity and health impairment. Since 2009, the World Health Organization (WHO) and the Center for Disease Control and Prevention (CDC) have recognized ACEs as a public health problem (CDC, 2010; WHO, 2009). A meta-analysis conducted by Hughes et al. (2017) found that between 1% and 38% of the population reported having experienced four or more types of ACEs. Furthermore, the cumulative effect of ACEs has been recognized: the greater the exposure and emotional burden, the greater the long-term impact (Schalinski et al., 2019; Rod et al., 2020). ACEs appear to be a risk factor for the onset of psychological

distress in general and have been associated with the development of personality disorders, depression, anxiety, substance abuse, post-traumatic stress, suicide ideation or attempts, and psychotic experiences (Felitti et al., 1998; Sachs-Ericsson et al., 2015; Varese et al., 2012).

This overall association between mental health problems and childhood adversity cannot be considered in isolation if we are to understand how such a relationship comes about. It is therefore necessary to further explore how different psychological variables—coping styles, emotion regulation, or affective attachment—can affect the lives of people who have experienced adversity in childhood and who present with psychopathological problems in adulthood. Coping strategies have been linked to recovery from traumatic events and to mental health (Arslan, 2017; Van der Hallen et al., 2020). A distinction is often made between problem-approach and problem-avoidance strategies, or between problem-focused and emotion-focused strategies (Carver, 1989; Lazarus & Folkman, 1984). Approach strategies have been associated with better mental health; avoidance strategies with increased psychological distress and suicide risk. While approach strategies appear to buffer the effects of ACEs, the tendency in these situations is to resort to the use of avoidance strategies (Arslan, 2017; Brooks et al., 2019). As for emotion regulation, it is the ability to influence one’s own emotions—recognizing, expressing, and modulating them in an adaptive way (Gratz & Roemer, 2004). In the face of adversity, people need to both solve problems and regulate their emotions (Ortega-Maldonado & Salanova, 2016; Stanislawsky, 2019). Some authors consider dysregulation as a transdiagnostic factor (Cludius et al., 2020). Yet effectiveness in coping and regulation needs to be assessed in terms of the individual’s resources and the demands of the situation (Ortega-Maldonado & Salanova, 2016; Wang et al., 2016). Many of the behaviors and reactions described as psychopathological symptoms can in fact be relatively effective ways of dealing with chronic adverse situations. Emotion regulation and coping strategies developed in childhood and adolescence through processes of mutual co-regulation and modeling with attachment figures may be difficult to modify or replace; used in adulthood, they may impede the ability to use personal and interpersonal resources and can compromise mental health (Eisenberg et al., 2010; Rudenstine et al., 2019; Sheffler et al., 2019).

Through relationships with their primary attachment figures, people form expectations about themselves and others; they develop representational schemes to interpret what happens to them, and procedures to adapt to the environment in which they live (Bowlby, 1979). Exposure to violence in childhood promotes the formation and maintenance of negative schemes about oneself, others, and the world, making it difficult to build secure relationships. Having links with people who provide support and who are available and accessible has a buffering effect on the stress caused by adversity, but ACE-exposed children often have limited access to positive relationships, and their attachment figures may in fact be the source of the trauma (Choi et al., 2020). Formed in childhood, these schemes and insecurities in relationships with others persist into adulthood and can be transferred to relationships that are developed in the present.

It is estimated that the years of life lost to disability due to psychological problems are comparable to those lost as a result of chronic diseases such as heart disease or cancer (WHO, 2017), and evidence of the impact of early trauma on adult life highlights the need for ACEs to be considered as a relevant factor for mental health. In Spain, as in other countries, the prevalence of emotional

difficulties, poor self-perceived mental health, psychiatric diagnoses, and psychotropic drug consumption is higher among women (Abel & Newbigging, 2018; Centro Nacional de Epidemiología, 2018; Bacigalupe et al., 2020). Reflecting this reality, some international agencies stress that women have different risk factors for mental health than men. These factors include reproductive health, their role as primary caregivers, gender-based violence, and the higher prevalence of sexual abuse. These organizations also emphasize the need to implement a gender perspective in mental health research, through studies that consider gender from the outset and that involve women in addressing issues relevant to their health, such as violence and abuse (Abel & Newbigging, 2018; Department of Health & Social Care, 2018; Howard et al., 2017). As yet, few studies have combined this perspective with the influence of ACEs among adult women in Spain (Caravaca-Sánchez et al., 2019), and none, to our knowledge, have explored it among women mental health service users. The present study, carried out among women attending different public mental health facilities, sought a) to verify whether there is a direct relationship between exposure to ACEs and psychopathological symptoms on the basis of the number and types of adversity; b) to evaluate the relationship between specific variables—coping styles, emotion regulation, and adult attachment relationships—and psychopathology; and c) to examine whether ACEs can affect these variables and therefore indirectly influence women’s mental health.

## Method

### Participants

The sample was made up of women over the age of 18 who were receiving psychotherapy from the public health services of the Principality of Asturias and Catalonia (Spain). All subjects were adults and were not affected by intellectual disability, organic brain damage, central nervous system problems, or communication difficulties that might impede evaluation. The background characteristics of the sample are shown in Table 1.

*Table 1*  
Sociodemographic Characteristics of Sample (N = 207)

Variable	n	%
Education level		
No education or primary education unfinished	2	1
Primary education	28	13.4
Secondary education	27	12.9
High school diploma/Basic vocational training	71	34.4
Higher-level vocational training	33	15.8
University	46	22.5
Employment status		
Self-employed	22	10.5
Employee	97	46.9
Unemployed	36	17.7
Retired	8	3.8
Disabled	22	10.5
Student	22	10.5
Main source of income		
Job	148	71.5
Social Security	28	13.5
Government benefits	15	7.2
Other	16	7.7

Our sample size was 207 subjects with a mean of 41.54 years ( $SD = 14.04$ ,  $Mdn = 42$ ). In all, 61.4% of the participants were taking psychotropic drugs at the time of the evaluation and 66.7% had done so previously. A total of 46.4% were attending psychology services only; 53.1% were attending psychology and psychiatry services. In terms of the age at which they had first consulted mental health services, 51.7% had done so as adults, 29.0% as adolescents, 12.1% as children, 3.9% as young children, and 3.4% as older adults.

### Instruments

*Symptom Assessment-45 Questionnaire (SA-45)* (Davison et al., 1997), validated for a Spanish population by Sandín et al. (2008). This is a self-completed report with 45 items that describe psychopathological symptoms. The subject is asked to indicate the degree to which they have experienced the symptom in the previous week, between 0 (not at all) and 4 (a lot or extremely). The items are grouped into an overall score and nine subscales: Somatization, Obsessive-Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. In the current study, only the overall score—the Global Severity Index (GSI) of psychopathology—was considered; it produced a Cronbach's  $\alpha$  of .96.

A Spanish translation of the *Adverse Childhood Experiences Questionnaire* (Felitti et al., 1998) was used to evaluate adverse experiences of abuse, neglect, and household dysfunction during the first 18 years of life. Ten adverse experiences were assessed: physical, emotional, and sexual abuse; physical and emotional neglect; parental divorce or death; witnessing domestic violence; household substance abuse; household mental illness or having a family member attempt or die by suicide; and having an incarcerated household member. The frequency with which the person experienced them was determined by summing the 10 items. In this study, the reliability was  $\alpha = .80$ .

*Hardship*: socioeconomic vulnerability was assessed using a scale, developed for this study, which measures difficulty in covering unavoidable costs, in accessing training or employment, and in carrying out administrative procedures in the previous three months (0=never, 1=on one occasion, and 2=on more than one occasion). Participants could therefore score between 0 and 6 (0=no hardship, 6=hardship on more than one occasion in all three areas) (Cronbach's  $\alpha = .63$ ).

*The Coping Strategies Inventory (CSI)* by Tobin et al. (1989) in its Spanish version (Cano et al., 2007), evaluated eight coping strategies on a five-point Likert scale. Respondents had to briefly describe a stressful event or situation that had happened to them in the previous month and answer 40 statements, on a scale of 0 (not at all) to 4 (completely), rating the extent to which they experienced certain thoughts or feelings or displayed certain behaviors in relation to the chosen situation. Scores were obtained for eight scales: Problem Solving ( $\alpha = .82$  in our sample), Cognitive Restructuring ( $\alpha = .82$ ), Social Support ( $\alpha = .81$ ), Express Emotions ( $\alpha = .86$ ), Problem Avoidance ( $\alpha = .57$ ), Wishful Thinking ( $\alpha = .67$ ), Social Withdrawal ( $\alpha = .70$ ), and Self-Criticism ( $\alpha = .81$ ).

*Difficulties in Emotion Regulation Scale (DERS-E)* by Hervás and Jódar (2008) is the Spanish version of the scale developed by Gratz and Roemer (2004). Composed of 28 items in Likert-type format, the scale requires respondents to report the degree to which specific experiences occur in their daily lives, from 0

(almost never) to 5 (almost always). Scores were obtained for five scales: lack of control (Decontrol) ( $\alpha = .91$  in our sample), lack of emotional attention (Inattention) ( $\alpha = .77$ ), emotional rejection (Rejection) ( $\alpha = .91$ ), emotional confusion (Confusion) ( $\alpha = .79$ ), and life interference (Interference) ( $\alpha = .89$ ).

*The Scale of Preferences and Expectations in Close Interpersonal Relationships (EPERIC)* (Fontanil et al., 2013) assesses adult attachment styles. The questionnaire is made up of 22 items, each with a Likert-type response on a scale of 1 (is nothing like what happens to me) to 5 (is very much like what happens to me). It assesses Fear of Rejection or Abandonment by Attachment Figures (FRA) ( $\alpha = .88$  in our sample), Desire for Closeness (DC) ( $\alpha = .66$ ), and Preference for Independence (PI) ( $\alpha = .69$ ).

### Procedure

The study was approved by the Research Ethics Committee of the University of Oviedo, the Ethics Committee for Research with Medicines of the Principality of Asturias, and the Catalan Institute of Health; and the process was carried out in compliance with the ethical principles of the Helsinki Declaration. Those who met the requirements were informed of the aims of the research. After agreeing to participate in the study they were asked to sign an informed consent form.

### Data Analysis

The supposition of normality was checked using the Kolmogorov-Smirnov test, finding non-normality of distribution for 13 of the 20 variables. Following that, Spearman's correlation tests were performed. To compare the sample for each of the ACEs, the Student's t-test was used for the normally distributed variables and the Mann-Whitney U-test was used for the others. Multiple linear regression analysis following the stepwise method was performed using the GSI of psychopathology as a dependent variable. Possible predictors considered were age, education level, number of ACEs, hardship, coping styles, emotional regulation, and attachment. The stepwise method was chosen because it continuously checks the contribution of each independent variable as it is added to the regression model, eliminating any variables whose contribution to the model is better explained by another. In each case the supposition of independence of residuals was verified with the Durbin-Watson statistic, and the normality of their distribution, which justified the use of the analysis despite the non-normality of the variables, through the Kolmogorov-Smirnov test. The bilateral level of significance established prior to all the tests was .05. The statistical analyses were carried out using SPSS v20.0.

## Results

### Descriptive Analysis of GSI, ACE Data

The mean GSI was 72.9 (min. 40.5, max. 175.5), the median 75.15, and the standard deviation 36.9.

With regard to ACEs, only 13.5% of the sample subjects reported no adversity, whereas 48.3% had experienced four or more types, including two participants who had experienced all ACEs. This is therefore a sample with a high incidence of ACEs.

Figures on the frequency and percentage are shown in Table 2. There are noticeable differences between our sample data and

those of the original ACE Study, in which the percentage of people who reported no adversity was 36%, and 16% had a score of 4 or more points.

The most frequent forms of adversity experienced by our sample were emotional neglect and abuse, while the least represented were having an incarcerated household member and physical neglect (Table 3). Once again, there were differences when we compared our results with the baseline study. In the original ACE Study, the most frequently cited forms of adversity were physical abuse and sexual abuse.

*Association Analysis*

The correlation between the GSI and the number of ACEs was significant ( $\rho = .199, p = .004$ ).

The analysis by type of ACE revealed that emotional abuse, sexual abuse, emotional neglect, physical neglect, and mental disorder or family member attempt or die by suicide were associated with a worse GSI score (Table 4).

This direct relationship between ACEs and the GSI can be supplemented by an analysis of other variables that may be related to both. The first step was to examine the correlations between the GSI and the rest of the predictor variables, and then to perform regression equations to show the predictive weight of these variables (Table 5). The results showed non-significant associations for age, three coping strategy subscales (emotional expression, wishful thinking, and problem avoidance), and two

affective attachment subscales (preference for independence and desire for closeness).

*Regression analysis on significant variables for the GSI of psychopathology*

First, we performed forward stepwise multiple regression analysis on the statistically significant variables whose residuals were normally distributed (Table 5). The regression equation included four variables that explained 56.2% of the variance ( $R = .749, R^2 = .562, Durbin-Watson = 1.881$ ): Fear of Rejection or Abandonment ( $\beta = .313, p = .000$ ), Decontrol ( $\beta = .311, p = .000$ ), Rejection ( $\beta = .230, p = .001$ ), Cognitive Restructuring ( $\beta = -.156, p = .001$ ).

In order to examine another pathway through which ACEs can influence the GSI, the scores obtained in each of the predictor variables were then compared using the Mann-Whitney U statistic, or the Student's t-test for normally distributed variables, based on respondents' answers on whether they had experienced a particular ACE or not.

The right-hand side of Table 6 shows the statistically significant relationships for the predictor variables associated with the GSI. The distribution of fear of rejection or abandonment was statistically different for emotional abuse, sexual abuse, emotional neglect, and household mental disorder or suicide. For the emotion regulation strategies associated as predictors for the regression equations, the U results on the right-hand side of Table 6 show that decontrol also appears to be influenced by experiences of emotional, physical, and sexual abuse; emotional neglect; and of household mental disorder or suicide attempt, while rejection was more common in people who reported having experienced sexual abuse and emotional neglect. The strategy of cognitive restructuring did not vary according to adverse experiences.

Discussion

Our study into the impact of ACEs on adult psychopathology is one of only a few to have been conducted in Spain and, to our knowledge, is the only one in the country to involve a clinical sample of women. On the basis of national data showing a higher prevalence of psychopathology and higher use of mental health services among women, and following the recommendations of international agencies regarding research and the gender perspective (Abel & Newbigging, 2018; Department of Health & Social Care, 2018; Howard et al., 2017), we deemed it necessary to study the influence of ACEs on women users of mental health services. The most salient finding from our study is that, among the women attending psychotherapy services, psychopathological problems were more severe for those who reported exposure to multiple adversities in their childhood, and this also appears to be related to the use of certain strategies to cope with the problems and emotions that arise in their daily lives.

Our results complement those of the first ACE Study, in that they revealed a considerable prevalence of ACEs among a population that was middle class, mostly white, educated, and with access to health insurance. Other studies have supported the idea that the consequences of ACEs can affect any population, not only those usually associated with violence and maltreatment. In our study the frequency of ACEs was even higher when compared with the study by Felitti et al. (1998) and subsequent research carried out in

Table 2  
Frequency and Percentage of Adverse Childhood Experiences (ACEs)

Number of ACEs	Frequency	%
None	28	13.5
One	32	15.5
Two	21	10.1
Three	26	12.6
Four	24	11.6
Five	17	8.2
Six	20	9.7
Seven	16	7.7
Eight	12	5.8
Nine	9	4.3
Ten	2	1.0

Table 3  
Frequency and Percentage of Adverse Childhood Experiences (ACEs) by Type

ACE type	Frequency	%
Emotional abuse	105	50.7
Physical abuse	79	38.2
Sexual abuse	72	38.4
Emotional neglect	123	59.4
Physical neglect	28	13.5
Parental divorce or death	88	42.5
Witnessing domestic violence	59	28.5
Household substance abuse	84	40.6
Household mental disorder	93	44.9
Incarcerated household member	31	15.0

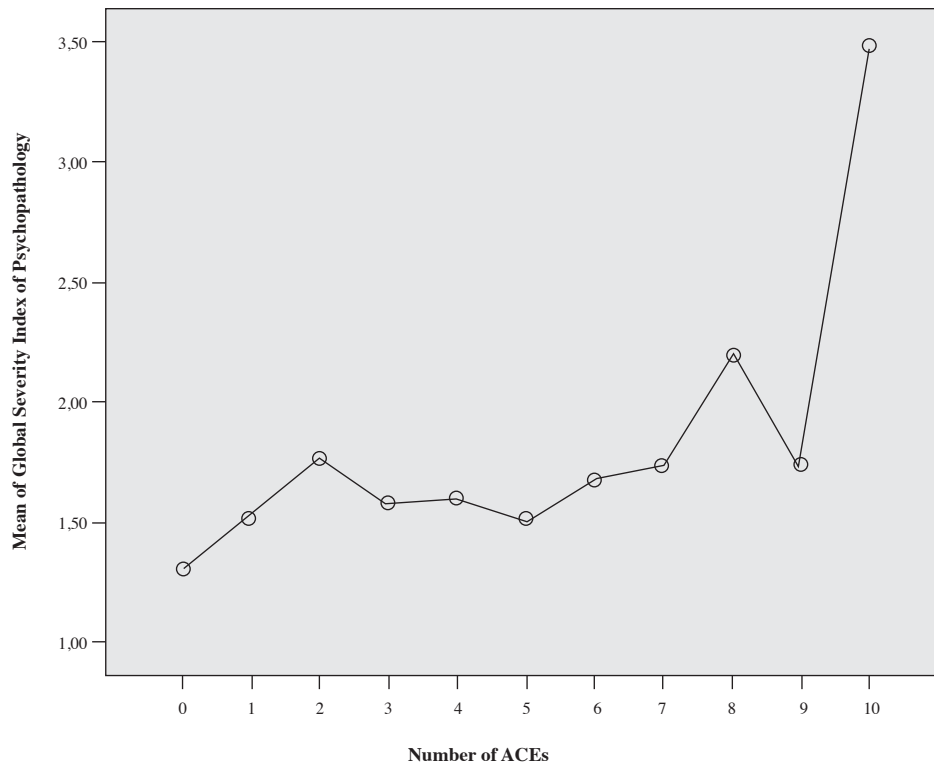


Figure 1. Relationship Between the Number of ACEs and Global Severity Index of Psychopathology

Europe and North America. Our findings suggest that women with mental disorders were exposed to an exceptionally high number of adverse experiences in their childhood. In fact, almost half of our sample had experienced four or more types of ACEs.

In this study, we sought to ascertain whether respondents who tend to give particular answers when asked about their psychological difficulties, their approach to problems, their ability to regulate their emotions, and their preferences and expectations in interpersonal relationships also tend to give particular answers when asked about adverse experiences during their childhood and adolescence. We indeed observed this pattern with our respondents; our interpretation of this finding is that people’s experiences influence what they remember and recount of their past and present.

*Table 4*  
Direct Associations Between Adverse Childhood Experiences (ACEs) and Global Severity Index of Psychopathology

ACE type	Mean of no	Mean of yes	Student's t-test	p
Emotional abuse (EA-1)	1.48	1.76	-2.56*	.011
Physical abuse (PA-2)	1.56	1.73	-1.49	.137
Sexual abuse (SA-3)	1.51	1.82	-2.61*	.010
Emotional neglect (EN-4)	1.43	1.75	-2.84**	.005
Physical neglect (PN-5)	1.55	2.06	-3.12**	.002
Parental divorce or death (PD/D-6)	1.55	1.72	-1.43	.156
Witnessing domestic violence (WDV-7)	1.59	1.69	-.76	.448
Household substance abuse (SA-8)	1.60	1.65	-.44	.660
Household mental disorder (MD/S-9)	1.51	1.77	-2.28*	.023
Incarcerated household member (IN-10)	1.58	1.89	-1.97	.051

Psychology relies on prospective longitudinal designs to establish whether certain psychological variables influence others; although prospective studies give more certainty, this confidence is based on the same assumption: certain experiences have an influence on

*Table 5*  
Spearman Correlations Between Predictor Variables and Global Severity Index of Psychopathology

Predictor Variable	Spearman's rho	GSI	p
Age		-.102	.146
Education level		-.137*	.049
Number of ACE types		.199**	.004
Hardship		.211**	.002
Decontrol		.650**	.000
Inattention		.226**	.001
Rejection		.601**	.000
Confusion		.512**	.000
Interference		.569**	.000
Problem solving		-.221**	.001
Self-criticism		.392**	.000
Emotional expression		-.047	.499
Wishful thinking		.135	.053
Seeking social support		-.227**	.001
Cognitive restructuring		-.211**	.002
Problem avoidance		-.056	.422
Social withdrawal		.324**	.000
Fear of rejection or abandonment		.566**	.000
Desire for closeness		-.002	.973
Preference for independence		.038	.588

*Table 6*  
Influence of Global Severity Index of Psychopathology Predictor Variables

Predictor variable	Beta (R <sup>2</sup> = <i>.562</i> )	Adverse Experiences Influencing Predictor Variables				
		Variable	NO Group	YES Group	Statistic	p
FRA (AAS)	.313	EA-1	Mean=2.67	Mean=3.03	t=-2.62**	.009
		SA-3	Mean=2.68	Mean=3.18	t=-3.45**	.001
		EN-4	Mean=2.53	Mean=3.07	t=-4.00**	.000
		MD/S-9	Mean=2.62	Mean=3.13	t=-3.69**	.000
Decontrol (ER)	.311	EA-1	MR=92.09	MR=114.69	U=4140**	.006
		PA-2	MR=95.88	MR=116.01	U=4016.5*	.019
		SA-3	MR=92.51 MR=92.51	MR=123.90	U=3351**	.000
		EN-4	MR=89.49	MR=113.14	U=3947.5**	.005
		MD/S-9	MR=91.69	MR=118.14	U=3897.5**	.002
Rejection (ER)	.271	SA-3	Mean=2.82	Mean=3.26	t=-2.52*	.013
		EN-4	Mean=2.77	Mean=3.11	t=-2.03*	.044
Cognitive restructuring (CS)	-.158					

*Note:* AAS=adult attachment styles ER=emotion regulation; CS=coping style; EA-1=emotional abuse; PA-2= physical abuse; SA-3=sexual abuse; EN-4=emotional neglect; MD/S-9=household mental disorder or suicide; MR=Mid-range; t=Student's t-test; U=Mann-Whitney U-test

others. Our results cannot prove causal relationships. Assuming the honesty of the participants, we can only infer similar backgrounds in the lives of people who report mental health problems.

In this sample of women attending public mental health facilities in Spain, the relationship between ACEs and psychopathology is clear. The correlation between the number of ACEs and the GSI is significant. The greater the number of ACEs, the stronger the relationship with worse self-reported psychopathology. On examining the importance of each individual ACE, we found that emotional abuse, sexual abuse, emotional neglect, physical neglect, and household mental disorder or suicide appear to be linked to a worse GSI score.

By extending our analysis to investigate the influence of other variables, we have seen how adverse experiences impact both directly and indirectly on the GSI. The number of ACE types to which these women were exposed at an early age is not an irreplaceable variable, and other variables are better GSI predictors. The relationship between psychopathology and the following variables is significant (in descending order of influence): Fear of Rejection or Abandonment, Decontrol and Rejection of Emotions, and lower use of Cognitive Restructuring; the value of these variables changes depending on the ACE types, such that the influence can be said to be indirect.

Our view is that people deal with ACEs by using the knowledge, skills, and preferences they have already developed or are developing, although the study does not allow knowing how or when they were originated. The relationship between ACEs and psychological problems can stem from the lack of psychosocial support and from the use of strategies that are useful in adverse circumstances, but unhelpful or even harmful in other contexts. The expectations and the procedural and declarative knowledge developed to adapt to childhood and adolescent adversity influence a person's later attempts to overcome difficulties and seize opportunities for adaptation in response to adverse situations that pose a threat to quality of life (Martín-Higarza et al., 2020).

The relationship between affective attachment that is based on fear of rejection or abandonment and a higher level of psychopathology is an expected outcome. The way in which ACEs can influence psychopathology through this pathway is consistent with the findings of earlier research (Alonso et al., 2018; Mikulincer & Shaver, 2012). Many of the ACEs describe situations where fear of rejection or abandonment is to be expected; indeed, emotional abuse and neglect, sexual abuse, and household suicide and/or mental disorder significantly influence this fear. The association between cognitive restructuring and better mental health also coincides with the findings of extensive research, although the degree to which these strategies are used does not change depending on early adverse experiences, suggesting that the source of this ability does not lie in family relationships, at least in abusive relationships. In contrast, emotional decontrol and the rejection of feelings are not only uniquely related to psychopathology but can also be a reaction to experiences of abuse and neglect. These findings are in line with the results of a study by Cloitre et al. (2019), who found that, among a sample of women being treated by mental health services, general emotion regulation difficulties mediate the relationship between ACEs and the severity of the psychological distress. The findings also agree with those of Rudenstine et al. (2019), who specified the mediating role of the rejection of emotions and the loss of emotional control.

The number and circumstances of the participants do not allow our results to be generalized. Our results can serve to elicit some hypotheses for further exploration with larger and more heterogeneous samples. The future leads to continue exploring this issue by making comparisons with men who receive assistance in Public Mental Health Services and exploring it with more complex analytical models. This study has the characteristic limitations of cross-sectional correlational studies that prevent a conclusion about the direction of the relationships between the variables involved. In addition, some of the subscales studied, such as problem avoidance, have had a low reliability that requires changes for their evaluation. What we have found reinforces the view that improving mental

health for the adult population of tomorrow involves reducing the adverse experiences for the children and adolescents of today. Such a change will not come about unless adult caregivers are provided with better parenting strategies, better living conditions, and better knowledge on how to give and receive care (Martín-Higarza et al., 2020; Merrik et al., 2019).

We believe that a lack of knowledge is one of the reasons why we health professionals do not ask about early adversity and the impact it has on our adult clients' daily lives, and the neglect and maltreatment can end up being reproduced in professional settings. Nevertheless, the appropriate and sensitive exploration of these experiences can be therapeutic. In fact, trauma-informed care, a movement advocating the implementation of trauma-informed therapeutic interventions, recommends this as a routine practice within mental health services. This approach offers a new perspective for understanding the human experience: it recognizes the prevalence of adversity in society and the damage it causes to health; it focuses on people and their experiences, but also on their strengths and their capacity for resilience (Dube, 2018; Finkelhor,

2018). However, to reiterate Becker-Blease's (2017) caution, the devil is in the details and the need to further our knowledge of trauma remains. Future research should identify areas of therapeutic intervention capable of enhancing interpersonal experiences that are not linked to abandonment or rejection, and that foster more positive management of emotions to prevent the rejection of feelings and the emotional blockage associated with conflict situations.

If prevention is one of the key pillars of public health, then the prevalence and damaging effects of ACEs call for a response that promotes primary and secondary prevention, with the aim of avoiding exposure to adversity in child and adolescent populations, and tertiary prevention through the recovery and healing of adult survivors (Dube, 2018). Facilitating the detection and assessment of ACEs, as well as implementing interventions to improve the quality of interpersonal relationships, coping strategies, and emotion regulation in adulthood, could buffer the long-term effects of early adversity, helping to avert the onset of many mental disorders.

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