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Childhood adversity and adult health-risk behaviors: Examining the roles of emotion dysregulation and urgency

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ABSTRACT

Adverse childhood experiences (ACEs) are important public health concerns, with links to higher prevalence rates of both health-risk behaviors and physical health difficulties in adulthood. Research has demonstrated an association between early adversity and long-term health-risk behavior development. The current study assessed the role of emotion dysregulation and facets of impulsivity as potential mediators in the relation between ACEs and general health-risk behaviors, including alcohol-related consequences and risky sexual behavior. College students (N = 668) completed online questionnaires that assessed history of ACEs, emotion regulation difficulties, impulsivity under extreme affect, and current engagement in health-risk behaviors. Emotion dysregulation and impulsivity under extreme positive emotion, but not negative emotion, demonstrated a significant serial mediation between ACEs and alcohol-related consequences. Results also suggest that emotion dysregulation mediates the relation between early adversity and all three outcomes (i.e., overall engagement in maladaptive behavior, alcohol-related consequences, and risky sexual behavior). Impulsivity under positive or negative affect did not demonstrate a mediation effect on the three outcomes. Results of this study highlight the importance of assessing for emotion regulation skills when working with young adults with histories of adversity.

1. Introduction

Adverse childhood experiences (ACEs) have important public health implications for a range of health care interventions, services, and screening procedures (Felitti et al., 1998; Felitti, 2017). Experiences of early adversity are heterogeneous in nature, including experiences of early trauma (e.g., child abuse and neglect, witnessing community and familial violence) as well as household dysfunction (e.g., having a caregiver with a mental illness, parental divorce, caregiver incarceration). Given the high exposure rates of early adversity across a range of populations (e.g., Dube et al., 2001; Felitti et al., 1998; Halfon, Larson, Son, Lu, & Bethell, 2017; Nurius, Green, Logan-Greene, Longhi, & Song, 2016), considerable research has been devoted to understanding the impact of these experiences on subsequent physical and mental health outcomes. Foundational research on ACEs demonstrates that increased experiences of childhood adversity are related to higher prevalence rates of physical health difficulties contributing to leading causes of death in the United States, such as cardiovascular disease, obesity, lung disease, and cancer (Felitti et al., 1998). These findings are well established and have been replicated across studies with both young adults and adolescents (e.g., Burke,

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Hellman, Scott, Weems, & Carrion, 2011; Dong, Dube, Gelittie, Giles, & Anda, 2003; Nurius et al., 2016).

Given the broad impact of early adversity across populations, research has attempted to understand factors that contribute to the relation between ACEs and health outcomes in adulthood. Higher engagement in health-risk behaviors (i.e., behaviors that can lead to health consequences), such as substance use and sedentary lifestyle, may contribute to these long-term health outcomes (e.g., Alcala, Mitchell, & Keim-Malpass, 2017). Health-risk behaviors may develop following ACEs as a means of coping with conflictual or stressful home environments (Repetti, Taylor, & Seeman, 2002; Rothman, Edwards, Heeren, & Hingson, 2008), in response to lack of caregiver supervision (Repetti et al., 2002), or following caregiver modeling of behavior (Alcala et al., 2017). It is probable that these health behaviors, in turn, contribute to disease onset (e.g., cardiovascular disease, lung disease, and cancer). The assertion that individuals with ACEs have higher rates of health-risk behaviors is well-supported (e.g., Alcala et al., 2017; Campbell, Walker, & Egede, 2016; Su, Jimenez, Roberts, & Loucks, 2015; Mersky, Topitzes, & Reynolds, 2013), with research linking increased ACEs to heavy alcohol use (e.g., Campbell et al., 2016; Chung et al., 2010), increased rates of smoking and illicit drug use (Felitti et al., 1998), and risky sexual behavior including increased number of sexual partners and higher rates of sexually transmitted illnesses (e.g., Campbell et al., 2016; Felitti et al., 1998). The effects of these high-risk behaviors on disease morbidity and mortality are robust. As such, it is essential to better understand the process that leads to health-risk behavior uptake in individuals with ACEs in order to inform targeted health interventions. The current study aims to examine the pathway from ACEs to health-risk behaviors through two specific mediators, namely, emotion dysregulation and impulsivity under extreme affect (also known as urgency).

Emotion dysregulation, or difficulty identifying and regulating one's emotions, has been studied in relation to early childhood adversity and its link to negative psychosocial outcomes in adulthood (Gratz & Roemer, 2004). Difficulties in emotion regulation following early childhood adversity are commonly reported and often contribute to high rates of depression, posttraumatic stress disorder, anxiety disorders, and overall distress (Chapman et al., 2004; Gratz, Tulle, Baruch, Bornovalova, & Lejuez, 2008; Mc Elroy & Hevey, 2014; Su et al., 2015). Following childhood trauma exposure, emotion dysregulation has demonstrated a significant effect on a number of psychosocial outcomes, including increased anxiety (Bender, Reinholdt-Dunne, Esbjorn, & Pons, 2012), relationship difficulties (Espeleta, Barton, & Messman-Moore, 2016), posttraumatic stress symptoms (Kim & Cicchetti, 2010), and higher risk for adult sexual victimization (Messman-Moore, Walsh, & DiLillo, 2010). However, research has yet to examine the specific role of emotion regulation on health-risk behaviors following ACEs. Difficulties in emotion regulation may occur following ACEs due to young children's underdeveloped abilities to identify or regulate their emotional experiences in response to stressful or conflictual environments (Morris, Silk, Steinberg, Myers, & Robinson, 2007; Schore, 2001). Furthermore, ACEs may disrupt the early processes of emotional development, causing deficits in development and utilization of long-term regulation strategies (Morris et al., 2007). This dearth of regulation strategies may then contribute to maladaptive coping strategies that serve to relieve emotional distress, especially during periods of intense emotion. For those unable to access beneficial strategies when experiencing intense emotions, resorting to impulsive behaviors may represent a seemingly effective way to cope with distress in the short-term.

Deficits in adaptive emotion regulation strategies likely contribute to increased impulsivity during highly emotional states, also known as urgency (Arens, Gaher, & Simons, 2012; Brodsky et al., 2001; Cyders & Smith, 2009). According to Cyders and Smith's model (2009), urgency can occur under positive (i.e., positive urgency) or negative (i.e., negative urgency) affective states. Though impulsivity is often viewed as a trait related to temperament and biological factors, research suggests that individuals with histories of childhood maltreatment demonstrate higher rates of impulsivity than their peers who did not experience maltreatment (Brodsky et al., 2001). Children with histories of maltreatment have been shown to demonstrate higher levels of negative affect and higher rates of negative urgency than their peers (Arens et al., 2012). Taken together, these findings suggest that individuals with emotion dysregulation resulting from early adversity may have access to fewer adaptive coping strategies and instead rely on impulsive coping strategies (e.g., substance use) when experiencing high levels of emotionality (Mirhashem et al., 2017; Oshri, Sutton, Clay-Warner, & Miller, 2015). Findings from Weiss, Tull, Viana, Anestis, and Gratz (2012) reinforce this indirect effect of trauma on impulsivity through emotion dysregulation amongst adults with substance use disorders. Collectively, this suggests that trauma-exposed adults are more likely to experience higher levels of emotion dysregulation, which in turn, increases their utilization of impulsive behaviors as a strategy to regulate extreme affect. However, no study to date has systematically examined the combined role of emotion dysregulation and positive and negative urgency on health-risk behaviors among individuals with ACEs.

The current study sought to address this gap by using a serial mediation model to test the theory that ACEs leads to emotion dysregulation, which in turn leads to impulsivity under extreme affect (positive and negative urgency) as a means of coping, which can then impact health-risk behaviors (Arens et al., 2012). Specifically, our study assesses the interplay between ACEs, emotion dysregulation, and urgency on health-risk behaviors such as alcohol misuse and risky sex. Given the prevalence of heavy drinking and risky sexual behaviors among college students, these particular health-risk behaviors are important outcomes to examine among this population (Hingson, 2010; Kiene, Barta, Tennen, & Armeli, 2009). The present study offers a unique contribution to the literature by expanding research examining child maltreatment and health-risk behaviors to include childhood adversity (i.e., household dysfunction and child maltreatment), health-risk behaviors, emotion dysregulation, and urgency within a single model. We hypothesized that higher levels of ACEs will predict more emotion dysregulation, which in turn will predict higher negative and positive urgency, which then predicts health-risk behaviors, specifically alcohol misuse and risky sexual behavior outcomes. Further, it is predicted that this overall model will remain significant when uniquely examining the specific health-risk behaviors of alcohol-related consequences and risky sexual behavior.

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