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Comparison of Scores for Abused and Nonabused Young Adults on the Psychological Trauma and Resources Scale

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Summary.- The Psychological Trauma and Psychological Resources Scale has been developed to identify adolescents and adults who have experienced traumatic events in their lives (i.e., physical, sexual, or emotional abuse and neglect). The scale also attempts to identify the presence of compensatory or resource factors such as social support that may serve to ameliorate the effects of traumatic events. College participants who reported a history of abuse were compared to a group of nonabused students on the seven subscales of the instrument. As predicted, the abused participants reported significantly greater incidents of abuse and neglect than the nontraumatized group. In addition, the abused group reported receiving less emotional support, and they were less likely to use positive self-talk as a way to decrease emotional distress. These results provide empirical support for using the Psychological Trauma and Psychological Resources Scale to identify individuals with a history of abuse, and the findings underscore the importance of assessing resource variables that may moderate the effects of abuse.

A growing number of empirical studies provide evidence that childhood physical and sexual abuse may increase the risk for subsequent development of serious and frequently chronic psychological disorders and social difficulties. Investigations involving adult outpatient samples have indicated that females with a history of abuse in childhood experience more depression, psychotic symptoms, interpersonal sensitivity, hostility, phobic anxiety, obsessive-compulsive thoughts, and sexual victimization in adulthood relative to nonabused comparison groups (Surrey, Swett, Michaels, & Levin, 1990; Muenzenmaier, Meyer, Struening, & Ferber, 1993). Trauma survivors are at greater risk for experiencing frequent depressive episodes of long duration. For example, Zlotnick, Warshaw, Shea, and Keller (1997) found that adults with a history of psychological trauma were more likely than those without such a history to have more than one episode of major depression, and they were less likely to remit over a five-year period. In addition, trauma survivors were more likely to report current or past alcohol abuse or dependence.

The prevalence of individuals with a history of abuse and psychological trauma can be particularly high among psychiatric inpatient samples. In their investigation of adult female inpatients, Craine, Henson, Colliver, and MacLean (1988) found that 51% of their randomly selected sample of subjects reported a history of sexual abuse as a child or adolescent. Bryer, Nelson, Miller, and Krol (1987) found that 72% of their adult female inpatients reported a history of abuse. Hospitalized subjects with a history of abuse scored significantly higher than nonabused inpatients on measures of depression, anxiety, paranoid and psychotic symptoms, borderline personality characteristics, interpersonal sensitivity, alcohol/drug abuse or dependency, somatic complaints, impaired sexual functioning, and low energy/chronic fatigue (Bryer, et al., 1987;

Craine, *et al.*, 1988; Brown & Anderson, 1991). In the Craine, *et al.* study, 66% of the sexually abused subjects met criteria for Post-traumatic Stress Disorder but previously had failed to receive this diagnosis. Abused patients experienced a greater incidence of suicidal ideation, gestures and/or attempts, and they received psychotropic medication more frequently than their nonabused counterparts (Bryer, *et al.*, 1987; Brown & Anderson, 1991). Regarding family functioning, sexually abused subjects also were more likely to report a greater family history of psychiatric illness and substance abuse (Craine, *et al.*, 1988; Brown & Anderson, 1991).

Similar negative effects have been found among abused adolescent samples. In their investigation involving adolescent inpatients, Sansonnet-Hayden, Haley, Marriage, and Fine (1987) found greater depressive symptoms, hallucinations, suicide attempts, and conduct symptoms among sexually abused subjects compared to a nonabused control group. As with adults, abused adolescents required more frequent use of neuroleptic medications and had longer hospital stays. Sexually abused adolescents did not differ in age, IQ, or occurrence of parental death from the nonabused group. However, abused subjects reported higher scores on a measure of psychosocial stressors over the past year and were more likely to come from lower socioeconomic backgrounds. Moreover, the sexual adjustment of abused adolescents was impaired. Compared to nonabused girls, the abused girls exhibited greater promiscuous sexual behavior or indicated fear and total avoidance of sexual activity. Sexually abused boys were more likely to engage in cross-dressing and half of the abused boys had molested younger children; none of the adolescents in the control group reported such behavior.

In a follow-up study of adolescent and young adult subjects, Burgess, Hartman, and McCormack (1987) found that the sexually abused group experienced chronic symptoms of Post-

traumatic Stress Disorder including flashbacks, anxiety and nervousness, excessive energy, inhibition of feelings, dissociation, fears (such as a fear of being alone), and intrusive thoughts. Compared to the nonabused group, sexually abused subjects also reported a history of stomachaches, sleeping difficulties, confused feelings about sex, and were more likely to engage in prostitution and compulsive masturbation. Alcohol, amphetamines, heroin, and psychedelics were used at a significantly greater level by the abused group. Subjects with a history of abuse reported greater interpersonal and family dysfunction and delinquent behavior. The abused subjects engaged in more physical fights with friends and parents than the nontraumatized controls. Survivors described their family members as less supportive and characterized family relationships as more conflictual, angry, and aggressive. In addition, subjects who experienced prolonged sexual abuse reported greater rates of legal problems, dropping out of school, running away from home, stealing from their family, breaking and entering homes, property destruction, engaging in physical assault without provocation, and using weapons.

Findings from a study conducted by Carmen, Ricker, and Mills (1984) involving adolescent and adult inpatients essentially replicate results discussed above. For instance, their abused subjects were more likely to have longer hospital stays and to report previous histories of suicidal and assaultive behavior, criminal justice involvement, and parental substance abuse (especially paternal alcoholism). This investigation also revealed gender differences in how abused males and females coped with anger during their hospitalization. Abused males, especially teens, were more likely than nonabused males and abused females to externalize their anger and to be aggressive, to have conduct disorders and legal charges, and to report psychosomatic symptoms. In contrast, abused females were more likely than other females to internalize their

anger and become depressed. Moreover, abused females tended to engage in repeated episodes of self-mutilation and suicide attempts; reported feelings of worthlessness, hopelessness, shame, and guilt; and exhibited marked impairment in self-esteem.

In summary, prior research provides evidence that physical and sexual abuse increases the risk for development of serious and frequently chronic psychological disorders and social difficulties (e.g., affective, anxiety, and psychotic disorders; substance abuse; suicidality; interpersonal problems). The Psychological Trauma and Psychological Resources Scale (PTPRS) was developed to identify adolescents and adults who have experienced traumatic events such as physical, sexual, or emotional abuse, and neglect (Holmes, Forand, Myers, Leonhardt, Caesar, Cuccaro, Hood, Stader, & McNulty, 1997). The scale is unique in that it examines both the incidence of abuse as well as compensatory or resource factors (e.g., social support) that may reduce the effects of traumatic events. The scale also gives respondents the opportunity to identify other negative life events (e.g., physical illness or injury, death of a parent or sibling) that may co-exist with incidents of abuse and increase the risk for subsequent development of psychological and interpersonal difficulties. Previous research has focused on development of the instrument and identifying scales through factor analysis. The present study is the first to investigate the scale's utility as a clinical instrument in identifying individuals with a history of abuse. Participants with a history of abuse were predicted to show significantly greater scores than the nonabused group on the Trauma subscales and to have significantly lower scores on the Psychological Resource subscales.

METHOD

Participants

The present study is based on 562 college students who completed the Psychological Trauma and Psychological Resources Scale. Of these students, the Nonabused group is composed of 464 participants. The Abused group consists of 98 participants who endorsed at least one of seven selected items on the Psychological Trauma and Psychological Resources Scale reflecting a past history of physical and/or sexual abuse: (a) I was seriously injured by an adult on purpose, (b) An older adult forced me to touch their private parts, (c) I was kicked or hit with things by an adult, (d) I was touched in ways I did not like by an adult, (e) I was sexually abused by adults, (f) I was physically abused by adults, and (g) An older person touched my private parts when I did not want them to.

Measure and Procedure

Participants in the study were administered the Psychological Trauma and Psychological Resources Scale which consists of 92 questions that ask respondents to use a 4-point scale to rate the frequency of positive and negative or traumatic events in their lives (never = 1, seldom = 2, sometimes = 3, and often = 4). Participants also indicated the occurrence of each item across three developmental periods: birth to six years of age, 7 to 12 years, and 13 years and older. In a previous study, factor analysis of the PTPRS using a Promax rotation yielded four Trauma factor scales: Sexual Abuse, Physical Abuse, Emotional Abuse, and Abusive Environment, and three Psychological Resource factor scales: Supportive Environment, Verbal Coping, and Emotional Encouragement (Holmes, McNulty, Stader, Forand, & Myers, in preparation). Examples of questions include the following: Sexual Abuse scale: (a) An older person touched my private parts

when I did not want them to, and (b) I was sexually abused by adults; Physical Abuse scale: (c) I was kicked or hit with things by an adult, and (d) I was grabbed, pushed, or shaken very hard by an adult; Emotional Abuse scale: (e) I was made fun of, and (f) I was rejected; and the Abusive Environment Scale: (g) I was physically forced to eat or drink things not good for me by an adult, and (h) I lived in dirty or unclean living conditions. Items on the three Psychological Resource factor scales include the following: Supportive Environment scale: (a) People paid attention to my needs, and (b) I was made to feel special or important; Verbal Coping scale: (c) When I was upset, I thought of different ways to handle the problem; and (d) When I was upset, I told myself to pay attention and think of a plan of action; and the Emotional Encouragement scale: (e) My family was there to support and care for me, and (f) I felt loved by my parents or guardians. To assess internal consistency, alpha coefficients were calculated for each scale and ranged from .75 on the Abusive Environment scale to .96 on the Supportive Environment scale.

RESULTS

A multivariate analysis of variance (MANOVA) was conducted to compare the Abused and Nonabused groups on the seven factor subscales identified above. The results indicated significant differences between the two groups when the subscales were considered together (Wilks' $F = 75.82$, $p < .001$). Between-group univariate comparisons showed that the Abused group had significantly higher scores on the four Trauma subscales, and lower scores on the three Psychological Resources subscales compared to the Nonabused group (see Table 1).

DISCUSSION

As predicted, results from the present investigation revealed significant differences in the occurrence of traumatic and positive life events between Abused and Nonabused participants.

The Abused group was more likely than the Nonabused group to report a past history of physical, sexual, and emotional abuse. In addition, the Abused group reported experiencing a more negative home environment with less support and emotional encouragement from others. The Abused group also was less likely to use verbal coping or positive self-talk as a way to decrease emotional distress.

As discussed, incidents of physical, emotional, and/or sexual abuse can precipitate a variety of psychological symptoms including depression, anxiety, suicidal ideation and attempts, alcohol and drug abuse, and impaired sexual adjustment. Among inpatient samples research has shown that abused adults and adolescents require more frequent use of neuroleptic medications and have longer hospital stays. Our findings were consistent with prior investigations indicating that abuse survivors report experiencing greater conflict and less support from their family and social relationships. In addition, they were less likely to use positive coping strategies than participants who did not report a history of abuse. The results regarding the Psychological Resource scales have significant clinical implications for treating individuals with a history of abuse. They underscore the importance of assessing the abuse survivor's family and social support network, evaluating coping skills, and targeting these areas for possible treatment intervention.

Given that the Psychological Trauma and Psychological Resources Scale shows promise in identifying victims of abuse, the authors plan to replicate the current study with an outpatient and inpatient psychiatric sample and to explore whether gender differences occur in the PTPRS results. In addition, we will examine whether other negative life events are likely to be present in addition to incidents of abuse. For example, Sansonnet-Hayden, *et al.* (1987) found that sexually

abused adolescents scored significantly higher than nonabused patients on a measure of psychosocial stressors. Negative or stressful life events may play a precipitating role in cases of abuse, may be a consequence of abuse, or may serve to exacerbate symptoms of abuse.

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Author Note

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Table 1

Comparison of Factor Subscales of the PTPRS for Abused and Nonabused Groups

	Abused (n=98)		Nonabused (n=464)		
Factor subscale	M	SD	M	SD	F(1, 560)
Trauma scales					
Sexual Abuse	1.41	.53	1.03	.08	217.12 **
Physical Abuse	1.69	.54	1.15	.18	303.21 **
Emotional Abuse	2.07	.64	1.62	.52	61.68 **
Abusive Environment	1.23	.32	1.06	.14	65.18 **
Psychological Resource scales					
Supportive Environment	3.29	.48	3.66	.30	100.70 **
Verbal Coping	2.94	.49	3.10	.43	10.70 *
Emotional Encouragement	3.25	.43	3.48	.33	37.00 **

* $p < .01$. ** $p < .001$.