



## Disgust as a unique affective predictor of mental contamination following sexual trauma



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### ABSTRACT

Mental contamination has been described as an internal experience of dirtiness that can arise and persist in the absence of contact with observable physical contaminants. Recent research has examined mental contamination specifically related to unwanted physical contact and sexual trauma. This study evaluated the degree to which disgust propensity and both self-focused and perpetrator-focused peritraumatic disgust were associated with mental contamination in a sample of women who experienced sexual trauma ( $n = 72$ ). Results showed that peritraumatic self-focused disgust, but not peritraumatic perpetrator-focused disgust or fear, was significantly associated with mental contamination. Additionally, disgust propensity contributed significantly to the incremental validity of the model. These findings support the nascent literature showing that disgust plays a significant role in mental contamination, particularly following sexual trauma. Future research directions, and clinical/theoretical implications of these results are discussed.

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Contamination, defined as “an intense and persisting feeling of having been polluted, dirtied, or infected, or endangered as a result of contact, direct or indirect, with an item/place/person perceived to be soiled, impure, dirty, infectious or harmful” (Rachman, 2006, p. 9), is a widely studied phenomenon linked to a number of affective (e.g., fear, anxiety, disgust) and cognitive (e.g., inflated beliefs about responsibility, beliefs regarding the spread of contaminants) vulnerabilities (Cisler, Olatunji, & Lohr, 2009; Rachman, 1997; Tolin, Worhunsky, & Maltby, 2004). Like most psychological constructs, contamination concerns exist upon a continuum ranging in frequency and severity, with distinct forms of psychopathology, most commonly contamination-based obsessive-compulsive disorder (OCD), falling upon the extreme end of the spectrum (Olatunji, Williams, Haslam, Abramowitz, & Tolin, 2008). Research in this area has traditionally focused on understanding mechanisms underlying the development and maintenance of contact contamination, or

contamination-related concerns that follow direct physical contact with a potential pollutant. This form of contamination is thought to result from a discrete source (i.e., polluting object), be contained to an identifiable site of contamination (e.g., hands, face), spread easily and widely to other people and objects through touch, and respond to cleansing or washing behavior (Rachman, 2004).

Recently, researchers have increasingly turned their attention to understanding a specific form of contamination referred to as mental contamination (or mental pollution), defined as “a sense of internal un-cleanness which can and usually does arise and persist regardless of the presence or absence of external, observable dirt” (Rachman, 1994). Mental contamination is theorized to emerge predominantly in response to mental events (e.g., thoughts, memories, images), or experiences involving negative human interactions such as violations of morality (e.g., sexual victimization or other violation), betrayal, or humiliation (Ishikawa et al., in press; Rachman, 2006, 2010; Rachman, Radomsky, Elliott, & Zysk, 2012). In contrast with contact contamination, sensations associated with mental contamination are typically described as diffuse, difficult to locate, with some individuals reporting feeling dirty “inside their bodies” or “under their skin” (Coughtrey, Shafran, Lee, & Rachman, 2012). Mental contamination does not require initial physical

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contact with a stimulus and often endures despite repeated washing or cleansing rituals (Coughtrey, Shafraan, et al., 2012; Fairbrother & Rachman, 2004).

Mental contamination may have important implications for understanding certain types of psychopathology, including both OCD and posttraumatic stress disorder (PTSD). For example, one study suggests that mental contamination concerns are experienced by nearly half of individuals with clinical diagnoses of OCD (Coughtrey, Shafraan, Knibbs, & Rachman, 2012). Moreover, mental contamination concerns have been consistently shown to correlate with severity of PTSD symptoms following sexual trauma (Badour, Feldner, Babson, Blumenthal, & Dutton, 2013; Badour, Feldner, Blumenthal, & Bujarski, 2013; Fairbrother & Rachman, 2004; Ishikawa et al., in press; Olatunji, Williams, et al., 2008). As the vast majority of individuals with a history of sexual trauma report experiencing at least transient mental contamination at some point following their assault (Fairbrother & Rachman, 2004), much of the research on mental contamination has been conducted among these samples. Related laboratory paradigms have been developed to serve as analogs for investigation of relevant processes involved in traumatic sexual victimization (Elliott & Radomsky, 2009; Herba & Rachman, 2007; Radomsky & Elliott, 2009, 2012).

The nascent body of research aimed at identifying mechanisms underlying the development and maintenance of mental contamination has focused primarily on the role of cognitive appraisals and vulnerabilities. For example, studies involving imagery of a past instance of sexual victimization as well as analog studies involving imagery of a non-consensual kiss at a party (i.e., *dirty kiss paradigm*) suggest cognitive appraisals such as beliefs about the degree of violation associated with an event, perceived responsibility for the event, and perceptions of the perpetrator (e.g., morality/immorality of character, physical cleanliness) may be involved in the development of mental contamination concerns (Elliott & Radomsky, 2009; Ishikawa et al., in press; Radomsky & Elliott, 2009, 2012). Preliminary evidence further suggests that posttraumatic cognitions, including those related to self-blame, negative beliefs about the self, and negative beliefs about the world, mediate the association between mental contamination and posttraumatic stress symptoms following traumatic sexual victimization (Olatunji, Elwood, Williams, & Lohr, 2008). Finally, general cognitive vulnerabilities linked to increased concerns with contact contamination such as inflated beliefs regarding responsibility and thought-action fusion (i.e., thinking about an unacceptable action is equivalent to carrying out the action or increases the likelihood that it will happen; Shafraan, Thordarson, & Rachman, 1996) have also demonstrated associations with mental contamination concerns (Cogle, Lee, Horowitz, Wolitzky-Taylor, & Telch, 2008).

As compared to cognitive factors, the role of specific emotions in the development and maintenance of mental contamination has received significantly less attention. This is notable, given that several emotions are theorized to be important within this domain (Fairbrother & Rachman, 2004; Rachman, 2004). Although several studies have examined how a range of negative emotions correlate with feelings of dirtiness and urges to wash elicited by the dirty kiss paradigm (Elliott & Radomsky, 2009; Elliott & Radomsky, 2013; Radomsky & Elliott, 2009), these studies have combined a number of negative emotions into single aggregate variables purported to index internal (i.e., shame, guilt, humiliation, fear, sadness, self-perception as cheap or sleazy) or external negative emotions (anxiety, distress, anger, disgust toward perpetrator's physical appearance or behavior). There are at least two critical limitations to this approach. First, one could argue that perception of the self as being cheap or sleazy involves cognitive appraisals, rather than affective constructs. Second, collapsing this broad range of negative emotions into aggregate variables

may result in loss of important information about specific emotional responses underlying mental contamination concerns. Other studies, including those reporting individual emotional responses (Rachman et al., 2012), have not examined correlations between affective variables and indices of mental contamination (Elliott & Radomsky, 2012; Ishikawa et al., in press).

Drawing upon theory and preliminary empirical research on mental contamination (Fairbrother & Rachman, 2004; Rachman, 2004), as well as our more robust understanding of affective mechanisms underlying contact contamination (for a review see Cisler et al., 2009), we might expect disgust to be one emotion particularly relevant in this domain. Disgust is a basic emotion characterized by a rejection/revulsion response thought to have initially developed as a protective mechanism aimed at preventing oral ingestion of potential contaminants in order to minimize contraction of illness or disease (e.g., Rozin, Haidt, & McCauley, 2000). It is thought that disgust has since evolved to distance organisms from a variety of other potentially harmful stimuli. For example, Tybur, Lieberman, & Griskevicius (2009) proposed three distinct domains of disgust, including pathogen disgust (e.g., disgust responses to contaminants that increase chance of illness or disease), sexual disgust (e.g., aversion to unconventional or potentially harmful sexual acts that increase illness probability and/or fail to produce progeny), and moral disgust (e.g., aversion toward perceived moral violations). It is easy to imagine that experiences involving sexual victimization may be capable of evoking any (or all) of these domains of disgust, and that such peritraumatic disgust responses may be involved in the development of mental and/or contact contamination concerns following the trauma (e.g., Badour, Bown, Adams, Bunaci, & Feldner, 2012; Badour, Feldner, Blumenthal, et al., 2013).

Preliminary evidence has linked disgust and disgust-related constructs to mental contamination. For example, significant correlations have been observed between disgust propensity (i.e., trait-like ease with which disgust is elicited by a variety of stimuli; van Overveld, de Jong, Peters, Cavanagh, & Davey, 2006) and feelings of dirtiness/urges to wash in response to the dirty kiss paradigm (Elliott & Radomsky, 2009) as well as with questionnaire-based measures of mental contamination (Radomsky, Rachman, Shafraan, Coughtrey, & Barber, 2014). Mental contamination has also been shown to mediate the association between disgust sensitivity (i.e., trait-like tendency to perceive feeling disgusted as negative; van Overveld et al., 2006) and sexual trauma-related posttraumatic stress symptoms (Badour et al., 2013b). However, other studies have not observed correlations between disgust propensity and trait measures of mental contamination (Cogle et al., 2008). Taken together, these studies suggest that disgust is an affective factor that likely plays a role in both mental contamination and symptomatic responding often linked to mental contamination.

Despite the emerging empirical evidence linking disgust-related constructs to mental contamination, little evidence documents the specific role of disgust itself. In the only study we are aware of in this domain, Badour, Feldner, Babson, et al. (2013) demonstrated that increases in state feelings of dirtiness correlated with concurrent increases in state disgust, but not increases in state anxiety, in response to idiographic imagery of a past sexual trauma. While these correlational results do not speak directly to the etiological role of disgust in mental contamination, it is possible that feeling disgusted during a traumatic event (i.e., peritraumatic disgust) may increase risk for developing mental contamination concerns following a sexual trauma. It has been suggested that self-focused disgust, in this case internalization of the disgust response associated with a trauma, may be particularly relevant to mental contamination (Badour, Feldner, Blumenthal, et al., 2013; Olatunji, Elwood, et al., 2008; Olatunji, Williams, et al., 2008). Indeed, perceiving disgust present during an assault as indicative of the self as being dirty or contaminated may lead to increased

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