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Self-disgust in mental disorders — symptom-related or disorder-specific?

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Abstract

Background: Dysfunctional disgust experiences occur in a variety of mental disorders. Previous research focused on disgust proneness directed towards stimuli in the external environment. However, self-disgust, the devaluation of one' own physical appearance and personality (personal disgust) as well as one' own behavior (behavioral disgust) has hardly been investigated thus far, although it may play a crucial role in specific psychopathologies.

Methods: We investigated 112 patients diagnosed with different mental disorders (major depression, schizophrenia, borderline personality disorder (BPD), eating disorders, and spider phobia) and 112 matched mentally healthy individuals. Participants answered the Questionnaire for the Assessment of Self-Disgust (QASD) with two subscales 'personal disgust' and 'behavioral disgust', and the Brief Symptom Inventory (BSI) that provides an overview of patients' psychological problems and their intensity.

Results: Compared to healthy controls self-disgust was elevated in mental disorders. Personal disgust was more pronounced than behavioral disgust in patients, whereas there was no difference in controls. Patients with BPD and eating disorders reported the highest scores on both subscales. Findings also suggest that self-disgust is related to specific psychological problems. In mental disorders psychoticism and hostility were the best predictors for personal disgust, while anxiety and interpersonal sensitivity predicted behavioral disgust. Additionally, we found disorder-specific predictors for personal disgust (e.g., hostility in schizophrenia). Finally, traumatic events during childhood constitute a risk factor for self-disgust.

Conclusions: The current study provides first evidence for the differential meaning of self-disgust for specific mental disorders and symptoms.

1. Introduction

Disgust is considered a basic emotion that is evoked by stimuli which possess particular features that connote disease [1]. In this sense typical disgust elicitors are spoiled food, poor hygiene, and contact with ill or dead organisms [2]. All of these stimuli are potential contaminants and disgust, as a disease-avoidance mechanism, motivates their rejection. In addition to these triggers of core disgust, Rozin et al. [2] have suggested that in the cultural evolution of humans further types of this emotion have evolved; specifically 'interpersonal disgust' and 'moral disgust'. These types of disgust are provoked by violators of social norms and orders and are closely associated with the complex disgust-derived emotions shame and guilt [3].

All of the aforementioned disgust elicitors can be found in the external environment and the induced repulsion from contact with these elicitors in turn insulates the self against others [2]. Elevated externally directed disgust proneness has been identified as a risk factor for the origin as well as for the maintenance of several mental disorders including specific phobias of the animal and blood type [4,5], obsessive–compulsive disorders (OCD) [6,7], eating disorders [8,9], schizophrenia [10,11], and borderline personality disorder [12,13].

Sometimes disgust is not directed towards the outside, but towards oneself. This kind of disgust response has been labeled self-disgust or self-loathing [3]. Self-disgust is related to 'moral' and social disgust [2,14], which is triggered by violations of social and moral norms. In this respect, self-disgust may function as a control mechanism of a person's interpersonal attractiveness and social acceptance.

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The experience of self-disgust is accompanied by physiological and behavioral processes similar to externally directed disgust [15,16].

Surprisingly, self-disgust has hardly been investigated thus far, although it has been suggested to play a critical role in several mental disorders [17]. Empirical evidence for increased self-disgust in depression has been obtained in a study by Overton et al. [16]. Based on a sample of 111 college students the authors developed a self-disgust scale (SDS). The overall SDS score was positively correlated with self-reports of depression. Further, self-disgust mediated the relationship between dysfunctional cognitions and depressive tendencies (see also Simpson et al.) [18]. In line with these findings, Schienle et al. [19] observed elevated self-disgust in a group of inpatients suffering from major depression.

Patients afflicted with anorexia nervosa and bulimia nervosa not only experience disgust towards certain foods (e.g., disgust-based avoidance of high-caloric food) but also feel disgust towards their own body, which is classified as being unattractive and repulsive [3,17].

Finally, research conducted by Rüsch et al. [12] suggested that self-directed disgust may be central for BDP. The authors used an implicit association task to measure self-loathing. This finding is in line with results reported by Schienle et al. [13]. In their study, 30 female patients afflicted with BPD and 30 healthy women had answered different measures of trait disgust, specifically disgust proneness, disgust sensitivity and self-disgust. BPD patients showed a broad spectrum of altered disgust processes including elevated self-loathing.

All aforementioned studies focused on one particular mental disorder. A comparison of self-disgust reported by different patient groups has not been conducted thus far. Also, the association between specific psychological problems and self-disgust has not been investigated. The aim of this study was therefore to analyze the meaning of elevated self-disgust for selected mental disorders and symptoms.

2. Methods

2.1. Participants

We studied 112 patients (93 women, 19 men) with a mean age of 30.8 years (SD = 12.3) diagnosed with different mental disorders (major depression: n = 21; schizophrenia: n = 15; borderline personality disorder (BPD): n = 17; eating disorders: n = 40; spider phobia: n = 19). Mean education level was 13.2 school years (SD = 3.2). Patients with depression, BPD, and schizophrenia were inpatients at the psychiatric hospital at the Medical University of Graz. In the patient group with schizophrenia 6 patients had the diagnosis 'paranoid schizophrenia', and 9 patients were diagnosed as schizoaffective. Participants with eating disorders and patients with spider phobia were outpatients at the University of Graz. From the patients with eating disorders 16 patients were afflicted with anorexia nervosa and 24 patients with bulimia nervosa. Sixteen patients had reported physical or/and sexual abuse during childhood.

The clinical sample was compared with 112 mentally healthy subjects (93 women, 19 men) with comparable age (M = 31.1 years, SD = 13.0; $t(222) = 0.20$, $p = .841$) and educational status (years at school: M = 13.8, SD = 2.9; $t(222) = 1.50$, $p = .135$).

The study was approved by the local ethics committee. All participating patients gave written informed consent.

2.2. Questionnaires

All participants answered the following self-report measures:

a) The Questionnaire for the Assessment of Self-Disgust (QASD) [19] is a self-report measure for self-disgust that can be used in clinical as well as non-clinical samples. The majority of the sample used for the questionnaire construction (n = 895) reported no mental health problems, whereas the remaining participants (n = 84) were inpatients of a psychiatric clinic. The questionnaire had been developed via exploratory factor analysis (principle axis factor analysis with oblique rotation) in the first subsample followed by confirmatory factor analysis for the data of the second subsample. The final QASD version contains two subscales: 'personal disgust' (9 items) assesses the devaluation of one's own physical appearance and personality (e.g., 'I find myself repulsive'), and 'behavioral disgust' (5 items) assesses the devaluation of one's own behavior (e.g., 'I regret my behavior'). The items have to be judged on 5-point scales (0 = 'not true at all'; 4 = 'absolutely true'). As the conditions under which Cronbach's alpha is a reliable estimate of the lowest bound of reliability have not been met, measurement accuracy was examined by Guttman's λ4 (see also Sijtsma [20]). For comparison purpose we still report Cronbach's alpha, which was 0.79 for 'personal disgust' and 0.91 for 'behavioral disgust'.

b) The Brief Symptom Inventory (BSI) [21] is a 53-item self-report inventory that provides an overview of a patient's symptoms and their intensity. It consists of nine symptom dimensions: Somatization ('Faintness or dizziness'), Obsessive–Compulsive ('Having to check and double-check what you do'), Interpersonal sensitivity ('Feeling inferior to others'), Depression ('Feeling no interest in things'), Anxiety ('Feeling tense or keyed up'), Hostility ('Having urges to break or smash things'), Phobic anxiety ('Feeling uneasy in crowds, such as shopping or at a movie'), Paranoid ideation ('Others not giving you proper credit for your achievements'), and Psychoticism ('The idea that something is wrong with your mind'). The items are rated on 5-point scales (0 = 'not at all' to 4='extremely'). The Cronbach's alpha ranges from 0.70 to 0.89.