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The Disgust Propensity and Sensitivity Scale-Revised: Psychometric properties and specificity in relation to anxiety disorder symptoms

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Abstract

The present study examined the factor structure and psychometric properties of the Disgust Propensity and Sensitivity Scale-Revised (DPSS-R) in a nonclinical sample ($N = 340$). Principal components analysis of the DPSS-R revealed a two-factor structure consisting of Disgust Propensity and Disgust Sensitivity. Although the two-factor structure converged well with prior research, four of the 16 DPSS-R items did not load onto the predicted factor. The DPSS-R demonstrated good reliability and validity. The DPSS-R and its two factors were moderately correlated with spider fear and contamination fear and mildly correlated with injection fear. The relation between the DPSS-R and these anxiety disorder symptoms remained largely intact after controlling for negative affect. Regression analyses also revealed that the two DPSS-R factors demonstrate specificity in the prediction of anxiety disorder symptoms. These findings are discussed in terms of promoting a more valid and reliable assessment of disgust in anxiety disorders.

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Descriptive and experimental research has implicated disgust in the development and maintenance of spider phobia (Olatunji, 2006), blood–injection injury (BII) phobia (Olatunji, Sawchuk, de Jong, & Lohr, 2006), contamination-based obsessive–compulsive disorder (OCD; Olatunji, Williams, Lohr, & Sawchuk, 2005), and eating disorders (Davey, Buckland, Tantow, & Dallos, 1998). There is also some evidence to suggest that disgust may account for the unique fainting response observed in BII phobia (e.g., Page, 2003), thought this finding has not been consistently replicated (e.g., Olatunji, Williams, Sawchuk, & Lohr, 2006). More recent research has also implicated disgust in hypochondriasis (e.g., Davey & Bond, 2006) social phobia (e.g., Montagne et al., 2006) and psychotic disorders (e.g., Schienle, Walter, Schäfer, Stark, & Vaitl, 2003). Accordingly, there has been increasing emphasis on the measurement of disgust in the context of psychopathology (Olatunji & Sawchuk, 2005).

Several measures of disgust have been developed to facilitate research examining the relationship between the experience of disgust and symptoms of psychopathology. The first such measure to appear was the Disgust and Contamination Sensitivity Questionnaire (DQ; Rozin, Fallon, & Mandell, 1984) that assesses the propensity to render perfectly edible food-items completely un-edible, merely via brief physical contact with perceived contaminants (Rozin & Fallon, 1987). Given that the DQ was largely limited to the food domain, the Disgust Scale (DS; Haidt, McCauley, & Rozin, 1994) was developed as a more comprehensive measure designed to cover a wider range of disgust domains, including foods, animals, body products, sex, hygiene, envelope violations (e.g., injections), death, and sympathetic magic (e.g., stimuli without infectious qualities of their own that either resemble contaminants or were once in contact with contaminants). The DS is the most commonly used measure of disgust and is widely regarded as the measure of choice for this construct (Olatunji & Sawchuk, 2005). The Disgust Emotion Scale (DES; Kleinknecht, Kleinknecht, & Thorndike, 1997; Olatunji, Sawchuk, de Jong, & Lohr, in press-b) was more recently developed as an alternative measure of multiple disgust domains (rotting foods, small animals, odors, injections and blood draws, mutilation and death).

Development of the DQ, DS, and DES has facilitated studies showing that the experience of disgust may contribute to a wide range of psychopathology symptoms (Olatunji & Sawchuk, 2005; Woody & Teachman, 2000). However, the DQ, DS, and DES are limited in several aspects (Arrindell, Mulkens, Kok, & Vollenbroek, 1999; Olatunji, Sawchuk et al., in press-b; Tolin, Woods, & Abramowitz, 2006). For example, all three disgust measures are context dependent. That is, each assesses disgust responses to specific elicitors. For example, the DS consists of items assessing disgust reactions to hygienic concerns (e.g., ‘‘I never let any part of my body touch the toilet seat in public restrooms’’) and the DES consists of items assessing disgust reactions to injection and blood draws (e.g., ‘‘Having blood drawn from your arm’’). Moreover, the item content of available disgust measures has substantial overlap with symptoms of specific anxiety disorders (e.g., OCD; BII phobia). Thus, findings that patients suffering from various anxiety disorders are characterized by higher disgust levels may be illusory and reflect shared item content between the DQ, DS, DES, and measures of anxiety symptoms.

Current disgust measures may also be limited in their assessment of the conceptual parameters of the disgust construct. Currently, such measures may be conceptualized as assessing ‘‘Disgust Propensity’’ or frequency of experiencing disgust in specific contexts. Although it has been suggested that ‘‘Disgust Sensitivity’’ or the perceived harmful consequences of experiencing disgust (cf. Reiss, 1991), may contribute to development and maintenance of symptoms of psychopathology (Olatunji & Sawchuk, 2005), available measures

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