Chapter 4

Disgusted by sexual abuse:
Exploring the association between
disgust sensitivity and posttraumatic
stress symptoms among mothers of
sexually abused children

Ivanka van Delft, Catrin Finkenauer, Joshua M. Tybur,
Francien Lamers-Winkelman

Under revision
Abstract

Non-offending mothers of sexually abused children often exhibit high levels of post-traumatic stress (PTS) symptoms. Emerging evidence suggests that disgust sensitivity plays a key role in the development of PTS symptoms. Yet, this has not been examined among victims of secondary traumatic stress. The current study examined associations between disgust sensitivity and PTS symptoms among 72 mothers of sexually abused children. Mothers completed the Impact of Event Scale-Revised and the Three Domain Disgust Scale. As expected, more than one-third of mothers reported high levels of PTS. Furthermore, higher levels of sexual disgust sensitivity were associated with more PTS symptoms. There were no associations between moral and pathogen disgust sensitivity and PTS symptoms. An interaction analysis showed that sexual disgust sensitivity was only associated with maternal PTS symptoms when the perpetrator was not biologically related to their child. Our findings suggest that sexual disgust sensitivity may be a risk factor for developing PTS symptoms among mothers of sexually abused children. This implies that disgust may be a promising target in the treatment of these mothers.
Non-offending parents of sexually abused children often exhibit posttraumatic stress (PTS) symptoms, which may persist up to 4 years after disclosure of child sexual abuse (CSA; e.g., Dyb, Holen, Steinberg, Rodriguez, & Pynoos, 2003; Kelley, 1990). Estimates suggest that 25-50% of parents develop clinical levels of PTS symptoms, including hyperarousal, avoidance, and intrusions (Davies, 1995; Dyb et al., 2003). Abundant evidence shows that emotional difficulties may undermine mothers’ ability to support their child in the aftermath of CSA (Cyr, McDuff, & Hébert, 2013; Elliott & Carnes, 2001). Furthermore, parental PTS symptoms are a strong predictor of children’s long-term PTS symptoms after exposure to trauma (Alisic, Jongmans, Van Wesel, & Kleber, 2011). Thus, it is important to identify and target key factors associated with mothers’ secondary traumatic stress reactions to their child’s CSA to promote both mothers’ and children’s adjustment.

To date, we know little about the etiology of PTS symptoms among victims of secondary exposure to traumatic events, particularly among parents of traumatized children. There is a clear need for extensive research to elucidate which factors may pose a risk for the development of PTS symptoms among non-offending mothers of CSA victims. One factor that has been overlooked in research—but that might be associated with mothers’ stress reactions to CSA—is mothers’ trait level disgust (i.e., disgust sensitivity). This gap in the literature is surprising given that disgust has been implicated as a key emotion evoked by exposure to traumatic events (Dalgleish & Power, 2004). The present study sought to examine whether disgust sensitivity is associated with PTS symptoms among mothers of CSA victims.

Disgust and CSA

Disgust is thought to have initially evolved to motivate the avoidance of infectious microorganisms (Tybur, Lieberman, Kurzban, & DeScioli, 2013). Disgust researchers have noted, though, that a wide variety of situations, acts, and stimuli that are not necessarily indicative of pathogens elicit disgust (e.g., Curtis & Biran, 2001; Rozin, Haidt, & McCauley, 2008; Tybur, Lieberman, & Griskevicius, 2009). Many disgust elicitors outside of the “pathogen” domains seem to relate to sexual behavior or moral transgressions (Tybur et al., 2009). For example, sexual violations (i.e., sexual assault and CSA) are found to elicit disgust (Feldner, Frala, Badour, Leen-Feldner, & Olatunji, 2010). To illustrate, victims often report elevated feelings of disgust toward the abuse, themselves, and their perpetrator (e.g., Feldner et al., 2010; Rahm, Renck, & Ringsberg, 2006; Rüscher et al., 2011). Also, sexual victimization elicits disgust in non-abused participants, particularly when victim and perpetrator are biologically related (Antfolk, Karlsson, Backstrom, & Santtila, 2012). These findings resonate with the assumption that disgust toward certain sexual behaviors—particularly those that rob an individual of sexual choice or present a biologically incompatible mate, such as kin—motivate
the avoidance of such couplings (Antfolk et al., 2012; Fessler & Navarrete, 2003; Tybur et al., 2013).

**Disgust sensitivity and PTS symptoms**

Across all domains of disgust, including moral, sexual, and pathogen disgust, trait-like individual differences in disgust sensitivity are found (Haidt, McCauley, & Rozin, 1994; Tybur et al., 2009). Research shows that these individual differences in disgust sensitivity, mainly toward pathogen cues, relate to traumatic responses (Bomyea & Amir, 2012; Rüsch et al., 2011). To illustrate, sexual assault victims with PTSD have higher disgust sensitivity than victims without PTSD (Rüsch et al., 2011). Also, more disgust sensitive individuals experienced more intrusive thoughts after watching a distressing film of severely burned individuals (Bomyea & Amir, 2012). In contrast, two other studies did not find an association between disgust sensitivity and PTS symptoms among soldiers and victims of sexual and physical assault (Badour, Bown, Adams, Bunaciu, & Feldner, 2012; Engelhard, Olatunji, & De Jong, 2011). However, none of these studies measured sexual and moral disgust sensitivity. In the context of sexual violations, it may be important to examine associations between PTS symptoms and a broader scope of disgust sensitivity.

All three of the types of disgust mentioned above could be relevant to sexual trauma. First, sexual violations may elicit specifically sexual disgust because they usually involve compromised sexual choice, which can elicit disgust (Fessler & Navarrete, 2003; Tybur et al., 2013). Second, sexual violations could also elicit pathogen disgust due to the close physical contact with a perpetrator and potential contact with bodily fluids (e.g., semen, sweat). Third, individuals often express and report experiencing disgust toward antisocial behavior that harms others, including deception, betrayal, and criminal behavior (Haidt et al., 1994; Tybur et al., 2009). Given that sexual violations are criminal offenses that may involve deception and betrayal, they might also elicit moral disgust.

**Mechanisms linking disgust sensitivity and PTS symptoms**

Little is known about the mechanisms through which disgust sensitivity may lead to PTS symptoms. Nevertheless, preliminary research shows that high disgust sensitivity is associated with enhanced levels of experienced disgust during a traumatic event (i.e., peritraumatic) (Engelhard et al., 2011). Research supports a model involving disgust-based conditioning in which intense experiences of peritraumatic disgust increases posttraumatic disgust-reactivity (i.e., react with high levels of disgust) to traumatic event cues (Badour, Feldner, Babson, Blumenthal, & Dutton, 2013a; Badour, Feldner, Blumenthal, & Knapp, 2013b). This, in turn, increases PTS symptoms (Badour et al., 2013a; Badour et al., 2013b; Olatunji, Babson, Smith, Feldner, & Connolly, 2009;
Shin et al., 1999). The model suggests that trauma-related stimuli are perceived as contaminating and threatening, contributing to PTS symptom severity by causing both cognitive and behavioral avoidance of and hypervigilance toward trauma-related stimuli (Bomyea & Amir, 2012; Engelhard et al., 2011). Taken together, the literature leaves little doubt that peritraumatic disgust may be a crucial mechanism through which disgust sensitivity leads to PTS symptoms. To our knowledge, these links have not been empirically tested yet among victims of secondary traumatic stress.

The current study
This study is a first step in elucidating the association between disgust sensitivity and PTS symptoms among mothers of sexually abused children. Our main aim was to examine whether higher levels of disgust sensitivity were associated with higher levels of maternal PTS symptoms. Based on existing research, we predicted that mothers’ disgust sensitivity would be positively associated with PTS symptoms. We further examined whether mothers had higher levels of PTS symptoms when (a) mothers had a history of experiencing CSA themselves; (b) the perpetrator was biologically related to the child; and (c) CSA was more severe (i.e., penetration). These factors have been associated with increased general psychological or emotional distress levels among mothers of CSA victims (e.g., Deblinger et al., 1993; Hébert, Daigneault, Collin-Vézina, & Cyr, 2007; Newberger, Gremy, Watrenaux, & Newberger, 1993).

Although interaction effects have not been tested in the literature, we expected that disgust sensitivity might moderate these three proposed predictors of PTS symptoms. For example, mothers’ sensitivity to sexual disgust might increase PTS symptoms especially when the perpetrator was biologically related to the child, because incest is particularly likely to elicit disgust (Antfolk et al., 2012; Fessler & Navarrete, 2003; Tybur et al., 2009). Therefore, we also tested for interaction effects.

Method
Participants
Participants were 72 non-offending mothers of sexually abused children (aged 4-16 years; $M = 9.76$, $SD = 3.90$; 66.7% female). As part of a larger (treatment) study, mothers were recruited from four outpatient treatment centers in the Netherlands specializing in childhood trauma (for full information about the sample and recruitment procedures, see Van Delft, Finkenauer, De Schipper, Lamers-Winkelman, & Visser, 2015). Their children were referred by the Dutch Youth Care Agency (in Dutch: Bureau Jeugdzorg), general practitioners, or mental health care professionals. Practitioners identified cases that included children aged 4 to 16 years who experienced (or were
suspected of experiencing) sexual abuse. Statements about CSA were deemed highly credible by the practitioners who did the intake and diagnostic assessments. Mothers were excluded when they had an intellectual disability (IQ score below 70) or were unable to complete the measures due to the inability to read or speak Dutch. For this study, we further excluded foster mothers. One mother was excluded for being unable to identify the perpetrator.

Most mothers (91.7%) had a Dutch cultural background. Nearly a fifth of mothers (16.7%) had a low family income (≤ 15,000 euro); half (45.8%) had a moderate family income (15,001-35,000 euro); and a fourth (26.4%) had a high family income (≥ 35,001 euro). Eight mothers (11.1%) failed to answer this question. Almost half of mothers had medium education levels (43.1%); more than one-third (38.9%) had a high education level; and ten mothers (13.9%) had a low education level. Three mothers (4.2%) failed to answer this question.

**Procedure**

Mothers were introduced to the study by a practitioner during intake and received an information letter and consent form. They gave permission to be contacted by a researcher to provide further information. Mothers provided informed consent to participate in the study and allowing the researchers access to their child’s treatment files. Before the start of treatment, mothers completed questionnaires guided by two trained research assistants at the treatment center or during a home visit. As a thank you for their participation, they received €25. The Medical Ethical Committee approved all of the procedures for this study (METc VUmc 2011/407/NL38753.029.11).

**Measures**

*Child sexual abuse characteristics.* Mothers reported on the identity and age of the perpetrator, the frequency of the abuse, and whether the perpetrator lived in the family home at the time of the abuse. Children’s treatment files were examined to assess CSA severity, which was scored by two independent coders using the Modified Maltreatment Classification System (MMCS; English & the LONGSCAN Investigators, 1997). Severity ranged from 1 (exposure to explicit sexual stimuli or activities) to 5 (forced intercourse or other forms of sexual penetration). Inter-rater reliability was adequate (Cohen’s Kappa = .72). Coder differences were resolved through discussion. A dichotomous variable was created with children who experienced penetration coded as 1 and other children coded as 0.

*Maternal history of sexual abuse.* The Adverse Childhood Experiences questionnaire (ACEs; Felitti, 1998) was used to assess mothers’ childhood maltreatment. Mothers were asked to report on experiences of sexual abuse with an adult at least 5 years older during their first 18 years of life. A dichotomous variable was created, with
mothers who experienced some form of sexual abuse coded as 1 and non-abused mothers were coded as 0.

Disgust sensitivity: The Three Domain Disgust Scale (TDDS; Tybur et al., 2009) was used to assess mother’s disgust sensitivity. The questionnaire consisted of 21 items measuring moral, pathogen, and sexual disgust. Participants rated the degree to which they found concepts described in the items as disgusting on a scale from 0 to 6 (0 = not at all disgusting, 6 = extremely disgusting). Mean scores were calculated with a higher score indicating higher levels of disgust sensitivity. The Dutch version of the scale has a similar factor structure, factor loadings, and internal consistency as the English version (Tybur & De Vries, 2013). All internal consistencies were adequate in this sample, with Cronbach’s alpha’s ranging from .77 (pathogen disgust) to .85 (moral disgust). Domains were moderately correlated (all r’s > .27, see Table 1).

PTS symptoms. The Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997; Dutch version: Kleber & De Jong, 1998) was used to measure maternal PTS symptoms. This questionnaire consisted of 22 items measuring symptoms of PTSD during the last week, including symptoms of intrusions, avoidance, and hyperarousal. Mothers rated the items on a 5-point Likert-scale ranging from 0 to 4 (0 = not at all, 4 = extremely). Mean scores were calculated with a higher score indicating higher levels of PTS symptoms. Furthermore, the cutoff for clinical levels of PTSD was set at a mean score of 1.5, as proposed by Creamer, Bell, and Failla (2003). Internal consistency (Cronbach’s alpha = .88) and validity of the Dutch version were adequate (Olde, Kleber, Van der Hart, & Pop, 2006). In our study, Cronbach’s alpha was .92 for the total score, .74 for avoidance, .82 for arousal, and .90 for intrusions. Subscales were highly correlated (all r’s > .50).

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<th>4</th>
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<th>6</th>
<th>7</th>
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<tbody>
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<td>2. Biological relatedness</td>
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<td></td>
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<td>3. Mother’s CSA history</td>
<td>.31*</td>
<td>.18</td>
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<td>4. PTS symptoms</td>
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<td>.16</td>
<td>.10</td>
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<td>5. Sexual disgust</td>
<td>.11</td>
<td>.07</td>
<td>.14</td>
<td>.39**</td>
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<td>6. Pathogen disgust</td>
<td>.13</td>
<td>-.03</td>
<td>.14</td>
<td>.13</td>
<td>.27*</td>
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<td></td>
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<td>7. Moral disgust</td>
<td>.16</td>
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<td>-.10</td>
<td>.05</td>
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<td>.40**</td>
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<td>Means</td>
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<td>.39</td>
<td>1.26</td>
<td>3.81</td>
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<td>Standard deviations</td>
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<td>.49</td>
<td>.74</td>
<td>1.32</td>
<td>1.15</td>
<td>1.13</td>
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</table>

Note. CSA = child sexual abuse, PTS = posttraumatic stress.

*p < .05

**p < .01
Data analysis
First, descriptive analyses were conducted to explore CSA characteristics, mother’s CSA experiences, and maternal PTS symptom severity in our sample. Second, zero-order correlations were conducted to examine bivariate associations among all study-related variables. Third, a hierarchical regression analysis was performed to examine whether CSA characteristics, mother’s CSA experiences, and disgust sensitivity relate to maternal PTS symptom severity. Interaction terms were included to examine possible moderating effects of disgust sensitivity. Continuous predictors were mean centered prior to model entry and before interaction terms were created (Aiken & West, 1991).

Results
Descriptives
More than one-third (38.9%) of mothers reported having experienced CSA themselves. The total mean score of maternal PTS symptoms approached the clinical cutoff of 1.5 (Table 1). Moreover, 28 mothers (38.9%) scored above the clinical cutoff. Almost half of the children (43.1%) experienced severe sexual abuse with penetration. One fourth (25%) of children experienced sexual touching and 5.6% were exposed to explicit sexual stimuli or activities, were asked for sexual contact, or were exposed to the genitals of the perpetrator. CSA severity was unknown at the time of intake for 20.8% of children, and intake information about CSA severity was not available for 5.6% of children. Mothers reported at intake that 37.5% of children experienced chronic sexual abuse and 19.4% experienced a single occurrence of sexual abuse. One-third of mothers (34.7%) did not know the frequency of abuse, and for 8.3% of children mothers failed to give specific information about the abuse. Most of the perpetrators were biologically unrelated to the child (61.1%).

Zero-order correlations
Bivariate correlations among study related variables are presented in Table 1. Consistent with our hypothesis, sexual disgust sensitivity was significantly positively associated with PTS symptom severity ($p = .001$). However, we did not find any associations between PTS symptoms and moral or pathogen disgust sensitivity. In contrast to our expectations, mother’s history of CSA, CSA severity, and biological relatedness of the perpetrator and victim were not related to PTS symptoms. We did find that mothers who were sexually abused as a child were more likely to have a more severely abused child ($p = .02$). Although girls ($M = 10.52$, $SD = 3.95$) were significantly older than boys ($M = 8.25$, $SD = 3.37$), $t(70) = 2.41$, $p = .02$, child gender and age were unrelated to the outcome measures.
Predictors of maternal PTS symptoms

In Step 1 of the hierarchical regression analysis, we entered mothers’ CSA history and biological relatedness of the perpetrator as predictors of maternal PTS symptom severity. We did not include CSA severity, because scores were missing for 26.4% of children. Results are presented in Table 2. Step 1 did not significantly explain variance in PTS symptom severity. Adding the three disgust sensitivity factors to the model in Step 2 significantly increased explained variance ($\Delta R^2 = .15$, $\Delta F(3, 66) = 3.92$, $p = .01$). Sexual disgust was positively related to PTS symptoms ($p = .002$), but pathogen and moral disgust were not ($p = .70$; $p = .60$, respectively). In Step 3, adding the interaction term Sexual disgust X Biological relatedness significantly increased explained variance ($\Delta R^2 = .06$, $\Delta F(1, 65) = 4.98$, $p = .03$). Both sexual disgust sensitivity ($p < .001$) and the interaction-term ($p = .03$) were significant predictors in the model. Because this was the only significant interaction, remaining interactions were not included in the final model. The interaction-effect was plotted (Figure 1) and a simple slope analysis was conducted (Aiken & West, 1991). This showed that when the perpetrator was biologically related to the child, PTS symptoms were similarly high regardless of maternal levels of sexual disgust sensitivity ($b = .05$, $SE = .10$, $p = .64$). However, when the perpetrator was biologically unrelated, mothers with higher sexual disgust sensitivity showed higher levels of PTS symptoms ($b = .33$, $SE = .08$, $p < .001$).

Table 2. Hierarchical Linear Regression Model Examining Posttraumatic Stress Symptoms as a Function of Mother's CSA History, Biological Relatedness, and Disgust Sensitivity

<table>
<thead>
<tr>
<th>Predictor Variables</th>
<th>B (SE)</th>
<th>B (SE)</th>
<th>B (SE)</th>
<th>B (SE)</th>
<th>B</th>
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<tr>
<td>Step 1</td>
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<tr>
<td>Mother’s CSA history</td>
<td>.11 (.18)</td>
<td>.07</td>
<td>.01 (.18)</td>
<td>.01</td>
<td>.03 (.17)</td>
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<tr>
<td>Biological relatedness</td>
<td>.23 (.18)</td>
<td>.15</td>
<td>.19 (.17)</td>
<td>.13</td>
<td>.20 (.17)</td>
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<td>Step 2</td>
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<tr>
<td>Sexual disgust</td>
<td>.22 (.07)</td>
<td>.39**</td>
<td>.33 (.08)</td>
<td>.60***</td>
<td></td>
</tr>
<tr>
<td>Pathogen disgust</td>
<td>.03 (.08)</td>
<td>.05</td>
<td>.06 (.08)</td>
<td>.09</td>
<td></td>
</tr>
<tr>
<td>Moral disgust</td>
<td>-.04 (.08)</td>
<td>-.07</td>
<td>-.06 (.08)</td>
<td>-.09</td>
<td></td>
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<tr>
<td>Step 3</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Biological relatedness X Sexual disgust</td>
<td>-.28 (.13)</td>
<td>-.32*</td>
<td></td>
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$R^2 = .03$, $SE = .18$, $p = .24$

$F = 1.14$, $SE = 2.86$, $p = 3.36$

$df = 2, 69$, $5, 66$, $6, 65$

$p = .33$, $SE = .02$, $p = .01$

Note. CSA = child sexual abuse.

*p < .05; **p < .01; ***p < .001
This study aimed to shed light on the association between disgust sensitivity and PTS symptom severity among mothers of sexually abused children. To our knowledge, this is the first study to differentiate between sexual, moral, and pathogen disgust sensitivity when examining the association between disgust sensitivity and PTS symptom severity. Furthermore, these associations have not yet been examined among victims of secondary traumatic stress. Consistent with our expectations, results indicated that mothers with higher levels of disgust sensitivity toward sex had higher levels of PTS symptoms, specifically when the perpetrator was biologically unrelated to the child. However, we did not find associations between moral and pathogen disgust sensitivity and PTS symptoms. Also, mothers’ CSA history, biological relatedness of the perpetrator, and CSA severity did not predict maternal PTS symptoms. Our results add to the limited body of literature examining risk factors of maternal PTS symptoms in the aftermath of CSA.

Consistent with previous research, one-third of the mothers had clinical levels of PTS symptoms, including symptoms of avoidance, hyperarousal, and intrusion (e.g., Davies, 1995; Dyb et al., 2003). Furthermore, replicating earlier findings, a significant amount of mothers of CSA victims had experienced CSA themselves (e.g., Finkelhor et al., 1997; Robboy & Anderson, 2011). However, our findings are inconsistent with existing studies showing that mothers of CSA victims experienced more distress when they had a history of CSA (e.g., Deblinger et al., 1993; Hébert et al., 2007; Hiebert-Murphy, 1998), the perpetrator was a family-member (Hébert et al., 2007), and CSA was more severe (Newberger et al., 2003). Our results suggest that although

Figure 1. Interaction between sexual disgust sensitivity and biological relatedness of perpetrator and child. For disgust sensitivity, low = one standard deviation below the mean and high = one standard deviation above the mean.

Discussion
these factors are associated with higher levels of general psychological and emotional distress, they may not be risk factors for developing PTS symptoms.

Our key finding was that, in line with our hypothesis, sexual disgust sensitivity predicted PTS symptoms among mothers of CSA victims. This is consistent with research showing that disgust sensitivity affects traumatic responses (Bomyea & Amir, 2012; Rüsch et al., 2011). Furthermore, our study suggests that the unique role of disgust in developing and maintaining PTSD may extend to victims of secondary traumatic stress. Models regarding the etiology of PTSD involving disgust-based conditioning (Badour et al., 2013b; Engelhard et al., 2011) may be useful when examining the impact of secondary traumatic stress. To this end, research into mechanisms linking disgust sensitivity and PTSD among victims of secondary traumatic stress is particularly important. For example, experimental studies should examine whether disgust sensitivity among victims of secondary traumatic stress increases peritraumatic disgust and disgust-reactivity to traumatic event cues, as found among victims of sexual violations (Badour et al., 2013a; Badour et al., 2013b).

Although our study shows that sexual disgust sensitivity is a risk factor for developing PTS symptoms, we found that this relationship was moderated by biological relatedness to the perpetrator. Sexual disgust sensitivity was only associated with PTS symptoms when the perpetrator was biologically unrelated to the child. These results may be explained by the previous finding that normal variability in sexual disgust sensitivity instruments does not covary with reactions to incest, presumably because virtually all individuals find incest disgusting (Tybur et al., 2009; see Lieberman et al., 2007, for a discussion of disgust toward incest). This coincides with our findings that mothers with low disgust sensitivity had higher stress levels in response to incest than when the abuse was not incestuous. Hence, the variability in sexual disgust sensitivity, as measured by the TDDS, was only related to intensity of distress toward the violation—and resulting PTS symptoms—when the violations were not incestuous.

Inconsistent with our expectations, pathogen and moral disgust sensitivity were not associated with PTS symptoms. Given previous findings, a lack of association between pathogen disgust sensitivity and PTS symptoms is particularly surprising (Bomyea & Amir, 2012; Rüsch et al., 2011). However, we were unable to control for CSA severity and maternal knowledge about the physical nature of CSA. CSA may particularly trigger pathogen disgust when it involves close physical contact with a perpetrator and potential contact with bodily fluids (e.g., semen, sweat). Furthermore, almost half of the mothers in our sample had no knowledge about the nature of their child’s CSA. Further investigation of the interaction between maternal knowledge of CSA, CSA severity, and pathogen disgust sensitivity on secondary traumatic stress may extend current findings.
Our results regarding moral disgust sensitivity may be explained by a debate in the literature regarding the validity of the moral factor of the TDDS (Olatunji et al., 2012; Olatunji, Ebesutani, & Kim, 2015). Researchers have suggested that this subscale might type variability in anger rather than disgust (Olatunji et al., 2012; Rozin & Haidt, 2013). To illustrate, anger was more strongly endorsed than disgust in response to the moral factor (Olatunji et al., 2012). Olatunji et al. (2012) suggest this may be explained by a lack of association between the moral factor and moral attitudes toward purity and sanctity, which primarily elicit disgust (Horberg, Oveis, Keltner, & Cohen, 2009). However, other studies show that moral transgressions beyond physical disgust stimuli, such as violations of social conventions, evoke disgust responses (for a review, see Chapman & Anderson, 2013). Thus, more research is needed to investigate the nature of moral disgust sensitivity and its role in developing PTSD.

Strengths and limitations
Some theoretical and methodological issues warrant attention and should be taken into account when interpreting our results. First, there is some debate regarding the extent to which the IES-R (Weiss & Marmar, 1997) can be used as a diagnostic tool for PTSD (e.g., Beck et al., 2008; Creamer et al., 2003). However, there is clear evidence for its usefulness in measuring traumatic stress (Beck et al., 2008; Creamer et al., 2003). Nevertheless, more research is needed to replicate our results, preferably with a diagnostic assessment of PTSD. Second, longitudinal studies of disgust sensitivity are lacking thus far, which raises questions regarding trait stability. Particularly because decreases in disgust sensitivity are found over short periods of time (Olatunji et al., 2012). However, test-retest reliability of the TDDS is considered excellent (Olatunji et al., 2012) and mean scores in our sample are comparable to mean scores found in previous studies across different samples (e.g., Tybur et al., 2009; Tybur & De Vries, 2013).

Despite these limitations, our study is a first step in understanding the role of disgust sensitivity in developing PTS symptoms among mothers of sexually abused children. Although it is widely recognized that these mothers may experience long-lasting significant distress and PTS symptoms (e.g., Dyb et al., 2003; Holt et al., 2014), we know little about risk factors for secondary traumatic stress symptoms (Hensel, Ruiz, Finney, & Dewa, 2015), particularly among mothers of CSA victims. Our study shows that sexual disgust sensitivity may be a vulnerability factor for PTS symptom severity, and that feelings of disgust may be a promising target in the treatment of these mothers. Research suggests that exposure-based treatment significantly reduces disgust (e.g., Olatunji, Smits, Connolly, Willems, & Lohr, 2007; Smits, Telch, & Randall, 2002), however, it has yet to be examined whether this extends to the treatment of PTSD.
References


Disgust Sensitivity and Posttraumatic Stress Symptoms


