

What Disgust Means for Complex Traumatized / Dissociative Patients: A Pilot Study from an Outpatient Practice

Ralf Vogt

Trauma Institute, Leipzig

Received 1 December 2011; accepted April 2012

Abstract

Although complex traumatized / dissociative patients frequently become traumatized under repelling circumstances, the role of repulsion or disgust has, until now, only been researched sparingly in the field of psychotraumatology. A few exceptions can be found in the field of psychosomatics, but in contrast with its brethren of basic emotions - fear, shame and grief (depression) - disgust does seem, however subconsciously, to be a taboo subject for both patients and trauma therapists. We are therefore happy to report that this pilot study, which was conducted in an outpatient psychotherapy practice with a sample size of 71 patients, was able to raise a number of new hypotheses regarding this hitherto neglected emotion.

Disgust may turn out to be an important diagnostic indicator. Our research showed that patients suffering from complex psychological trauma tended to suffer more from symptoms of disgust. They could also only overcome their disgust with exceedingly more difficulty than other client groups. Memories of disgust, which hark back to sexual abuse and violence inside the patient's own family, acquire special significance, as the patient is unable to digest these repellent experiences. Instead, the disgust they experience in such instances descends into the depths of the unconscious where it dwells for years. Symptoms of disgust, however oblique and concealed, coincide significantly with other psychosomatic symptoms, often exacerbating existing phobias, aggressive behaviour and shame.

Lastly, this article will also briefly look at ways of treating disgust effectively with the aid of interactive and physically oriented settings.

Abstracts of this article are to be found on the EABP website in the following languages: Albanian, French, German, Greek, Hebrew, Italian, Portuguese, Russian, Serbian, Spanish. <http://www.eabp.org/publications-journal.php>

Keywords: complex trauma, dissociative disorders, disgust, psychosomatics, psychological trauma predictor, PTSD

1. Introducing the research project

Disgust has been a recurring topic of interest in our practice in recent years based on a number of cases. As neither disgust nor the role of disgust in complex trauma had been the subject of many research studies, we decided to design a pilot study at the Trauma Institute Leipzig that would focus on the issues and questions relevant to us. This pilot disgust questionnaire (PDQ, see below) was designed to answer questions that arose in therapy sessions and was to take account of the invaluable input that was provided by advanced clients. In spring 2009 my wife, Irina Vogt, DP, and I selected a representative cross-section of our patient population and were able to interview a total number of 71 patients. The sample was structured as follows:

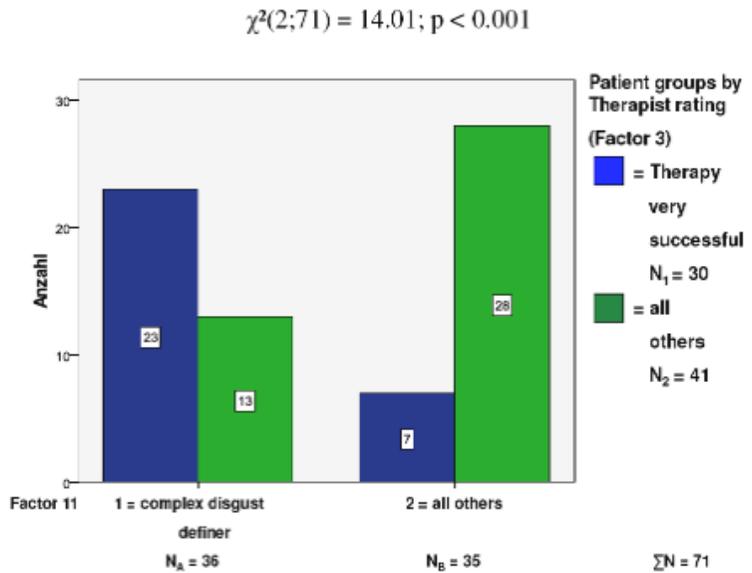
Sample structure		Women	Men	Σ
Number N		41	30	71
Age	Ø	38.1	39.2	
	from - to	25 - 71	25 - 51	
Hours	Ø	74.6	84.0	
	from - to	5 - 170	2 - 180	
Therapy phase in depth psychology/analytic psychology	Start	15	8	23
	Middle	10	10	20
	End	16	12	28
Diagnoses a) Complex and dissociative post-traumatic disorders	DID	6	4	10
	DESNOS/DDNOS	15	13	28
	PTSD	2	1	3
	Σ - trauma	23	18	41
b) Other types of disorders	Borderline personality disorders/structural disorders	6	7	13
	Neuroses, complex personality disorders	9	5	14
	Depressive reactions and other diagnoses	3	0	3
	Σ - others	18	12	30

Table 1.

Sample structure

As this table illustrates, approximately 58% (N=41 from 71) of the patients were complex traumatized patients suffering from dissociative identity disorder, chronic complex trauma, a chronic yet unspecified dissociative disorder or a fixated post-traumatic stress disorder. From here on, this particular group will be described as “trauma patients – total sample” in order to be able to adequately compare and contrast it with the other patients (N=30) of the sample. The statistic comparisons and hypotheses discussed in this article follow the same sequence of questions from the pilot disgust questionnaire. The expert rating scales which are cited and the legend of factors this yielded can both be requested from the author.

The objective of the introductory question was to explore to what extent our patients were able to define disgust, as we often observe major mentalization weaknesses in our trauma patients with regard to determining the notion of disgust. A general diagnostic comparison of the level of definition between trauma patients and other diagnostic groups did not yield a statistically significant difference. But a therapy oriented comparison between patients considered above average and highly successful in their therapy progress by two expert raters and patients considered average and comparatively less successful did produce a significant difference in the level of their disgust definitions. The following graph handsomely illustrates how:

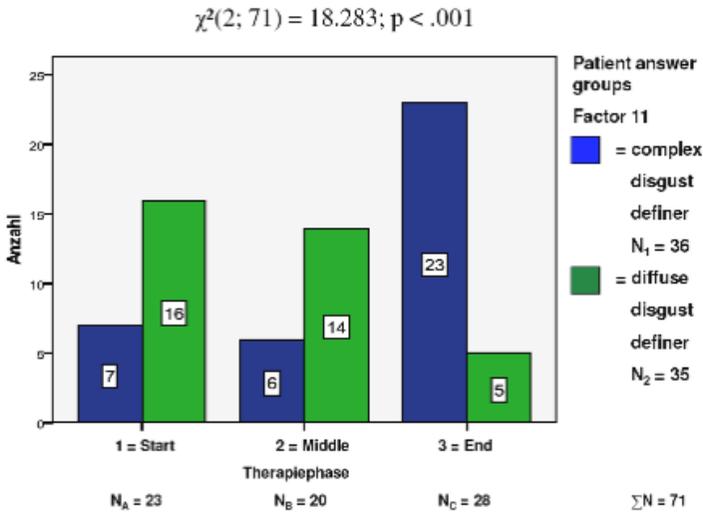


Graph 1.

Definitions of disgust depending on therapy success (Question 1 in PDQ and therapist rating TRUS)

Patients who included physical impulse reactions to disgust, mental boundary experiences and individual trigger or symptom associations in their subjective definitions of disgust were classified as complex disgust definers. Less competent disgust definers, on the other hand, revealed extensive self-assessment problems with regard to this affect /emotion. This was evidenced by their responses which were limited to associate disgust with particular diseases such as “herpes”, triggers such as “decomposing animals”, or a schematic flight reaction formulated as “I must run away from disgust”.

A further differentiated analysis of complex versus poor disgust defining skills is shown in Graph 2:



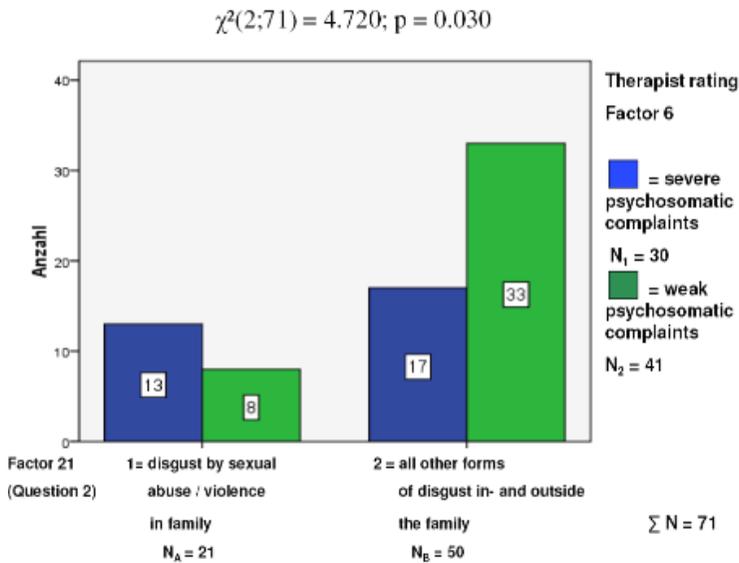
Graph 2.

Disgust definition depending on therapy phase (Question 1 in PDQ and therapist rating TRUS)

This graph clearly illustrates how the mental-emotional skill of complex disgust definers significantly improves in the third therapy phase, in which differentiation and integration are major themes. We therefore hypothesise that the skill to mentalize disgust is only acquired during the third therapy phase when the trauma exposition has been largely completed and the issue of disgust is overcome, enabling patients to better describe and deduce difficult emotional states.

A further evaluation of the responses to PDQ-Question 1 revealed that a large number of patients experienced tactile triggers, the merest suggestion of touch and/or observations thereof as disgusting. A similarly large number of our pilot group reported that a combination of smells in connection with visual cues or a combination of imagining the smell, sight and touch of something was thought to be extremely disgusting and that they were unable to overcome such sensual impressions over a long period of time.

The second item on the PDQ raised the question of which specific and individual experiences the patients concretely and subjectively remembered as particularly disgusting. Two internal raters then allocated the answers to 10 answer categories, which ranged from sexual violence, abuse and harassment within the family to unhygienic conditions and addicted family members to the same sexual and hygienic experiences of disgust outside the family, the sight of decomposing organisms, disease, wounds and many other experiences. Apart from summarizing these main categories we also conducted various statistical comparisons with other questions from the PDQ and with the therapist rating (TRUS). The most interesting and striking statistically significant result was perhaps the following (comp. Graph 3):



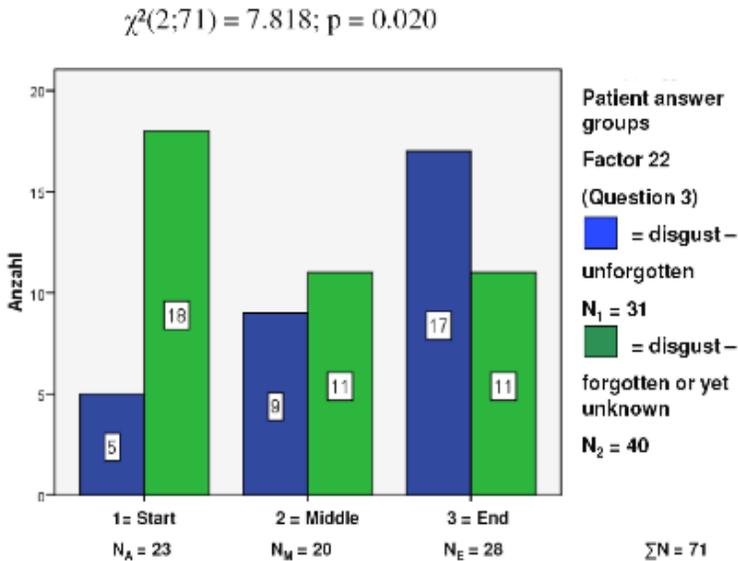
Graph 3.

Specific disgust and disgust experience in connection with psychosomatic complaints during treatment (Question 2 of the PDQ and therapist rating – TRUS)

This illustrates that disgust when experienced as an element of sexual violence and abuse within the family will have a lasting effect on a person. Psychosomatic complaints can therefore be considered a likely consequence: the connection is highly significant and the first physical complaints are reported to have appeared – as far as they can be remembered by those affected – after the abuse.

Another comparison with high statistical significance ($p = 0.016$ for $\chi^2(2; 71) = 5.844$) confirmed that disgust originating in sexual violence cannot be forgotten if the act in question occurred within the family of origin.

The following calculation for PDQ Question 3 set out to investigate to what extent specific categories of disgust are forgotten over a period of time or cannot be forgotten depending on the phase of the therapy (see Graph 4):



Graph 4.

Forgotten disgust depending on therapy phase (Question 3 in PDQ and therapist rating TRUST)

Two aspects in particular seem very interesting here. First, the proportion of patients who have forgotten or are unable to consciously remember disgusting experiences at the start of the therapy is noticeably high. Second, and in relation to this, the percentage of those remembering their disgust is higher at the end of therapy than at the beginning. An analysis of the context shows that the highest percentage of remembered or actually unforgotten experiences of disgust concern sexual acts of violence and abuse or other forms of disgusting uncleanliness inside the family. It is my hypothesis that therapy restores fragments of association chains which enable the patient to become aware of memories of incidents *in the form of reemerging disgust*. Such memories are never quite forgotten as patients may uncritically, or as part of an aspect of defensive traumaphobic behavior, like to believe (see also Van der Hart et al, 2008).

In Question 4 of the PDQ we therefore homed in on those experiences of disgust as a subcategory, which could *never* be forgotten in the patient's consciousness, and looked for separate connections between the symptoms.

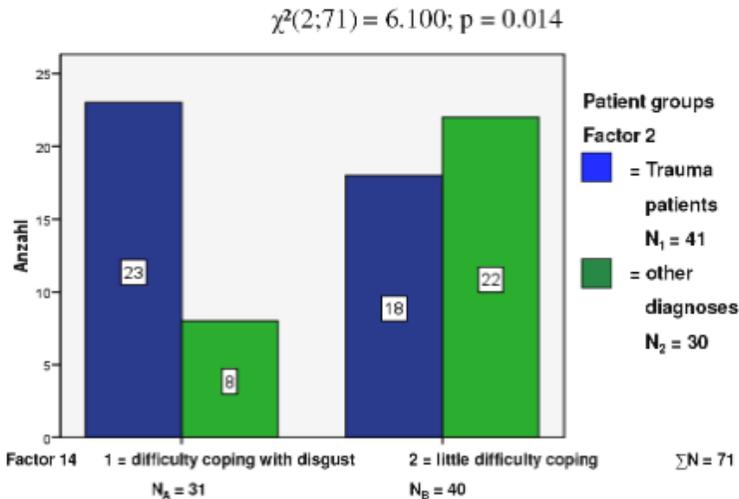
The cross table (graph 4.) makes clear that the patient group which was never quite able to forget the disgust experienced within the family was also the one which showed noticeably strong psychosomatic symptoms ($p = 0.043$ for $\chi^2(2; 71) = 4.096$).

Using the categorization deployed in our response analysis we reached a conclusion which was remarkably similar to the results in Graph 3 (see above). This means that disgusting experiences of sexual violence and abuse – just as other disgusting experiences – are first and foremost *considered particularly disgusting when occurring inside the family, and, secondly, are least likely to be forgotten*. They also show a statistically significant relationship with psychosomatic complaints, which the therapists are able to diagnose in the course of therapy.

Question 6 of the disgust questionnaire then asked the patients about their separate experiences of disgust, which have only come to light *because of the therapy*. The summarized answers to Questions 5 and 6 of the PDQ imply that approximately half the clients (N=35 for Question 5 and N=49 for Question 6) are unable to rediscover “early experiences”. The majority of “confirming rediscovered experiences” (in Question 5 – N=23 out of 36 “rediscovered experiences”) and completely surprising rediscovered experiences (in Questions 6 N=18 out of 22 “new discoveries”) can be grouped together under the headers sexual violence and abuse. This seems to suggest that, especially with regard to these charged topics, different repression and dissociation processes provide for a more temporary or fragmentary forgetting than with other experiences of disgust.

Question 7 asked something completely different of the patients. They were asked to compare their personal difficulty in coping with six of the most important basic emotions and rank them from 1 to 6.

The rankings provided by the patients were analyzed based on a group which “copes well with disgust” from the rankings 1 to 3 and a group which “doesn’t cope well with disgust” from the rankings 4 to 6 (see attached PDQ). Following this, a great number of statistical possibilities were investigated to see if there were any correlations. I found the following graph the most interesting (see Graph 5 and Table 2):



Graph 5.

Coping with disgust and psychological trauma (Question 7 in PDQ and therapist rating TRUS)

Graph 5 shows a strikingly high significant correlation between patients suffering from psychological trauma and severe difficulty in coping with feelings of disgust. Repeating this result in larger samples would mean seeing one of our basic clinical experiences confirmed, i.e. that patients suffering from the consequences of trauma do in fact struggle more with their feelings of disgust than do other patients.

From a clinical point of view, a higher deficit in coping with disgust could be compensatory and related to a higher dissociation value. We were only able to statistically confirm this suspicion as a tendency, in which our criterion (cut off $>/< 3 \times 30$ – i.e. three answer values in FDS-20 are greater than/equal to 30) was used as a clinical experience value. But in the end a certain degree of correlation between dissociation and difficulty coping with these feelings would be expected in our clinical sample.

In relation to the above results we used a detailed analysis to find out whether the ability to cope with disgust was different at the beginning or at the end of the therapy. Corresponding subcategory calculations confirm the general supposition that *those beginning therapy generally believe coping with disgust to be easier* – perhaps because they are at that point unable to remember disgusting experiences, or they perceive the fragments they can remember to be meaningless or not so troubling. Here it is shown clearly that out of 23 therapy beginners only 8 patients report difficulty in coping with disgust, whereas almost double as many – 15 patients – believe that feelings of disgust are no problem at all. However, things tend to look differently for the subcategory of those ending therapy. Out of the 28 patients that form this group a majority of 16 patients actually reports having great difficulty in coping with their feelings of disgust, whereas the rest reportedly has no great difficulty at all. Unfortunately, it was not possible to establish a significant relationship with these small samples, which means that this remains, for now, an open question to be answered in future.

Question 8 was dedicated to the problem of the subjective attribution of emotion. Is the basic emotion under discussion perceived to originate in physical or inner mental factors? As modern psychotherapists we obviously do not lend much credence to the obsolete dichotomy between mind and body. But these are the terms traditionally used by our patients and a great number of psychodynamic discussions we have with clients suffering from psychosomatic complaints often start off by distinguishing them between the physical and the mental. Seeing the difficulties clients had coping with their feelings of disgust, I hypothesised that the subjective determinants of the complaints may actually have been more physical.

I therefore decided to compare the median values of all the basic emotions under evaluation to see which were considered more physical or mental by the 71 patients (see Table 2).

Perceived disgust determinants in comparison:

	N	Mean	Standard deviation	Minimum	Maximum
disgust	71	3.72	1.845	1	7
fear	71	4.66	1.867	1	7
aggression	71	4.51	1.638	1	7
grief	71	5.18	1.366	2	7
shame	71	5.20	1.499	1	7
joy	71	4.97	1.558	1	7
	fear and disgust	Aggression and disgust	grief and disgust	shame and disgust	joy and disgust
Z	-3.062	-2.714	-4.698	-4.837	-4.118
Asymptotic significance (double-sided)	.002	.007	.000	.000	.000

Table 2.

Comparison between: disgust – fear, aggression, grief, shame, joy relative to physical / mental experience (Question 8 in PDQ – response analysis)

The result is rather astonishing, if only because it is surprisingly crystal-clear. First, disgust is not just physically experienced by the clients, but of all the basic emotions which were investigated, the ranking of median values leave no doubt that in the subjective perception of the clients it is the most physically determined emotion. Second, and perhaps most surprising of all, the difference between the median values of disgust and the other basic emotions proved to be *highly significant* for the 71 patients according to the Wilcoxon test. In other words, the subjective experience of disgust can really be designated a special role. However, the next question that arises is whether this is more relevant to patients suffering from trauma than to other patient groups. We therefore also compared the median values for trauma vs. non-trauma patients. The result was clear enough: our 41 trauma clients in particular experienced a stronger mental/non-random determinant in relation to the feeling of disgust.

Patients suffering from trauma were very clear in assessing disgust as something physical and non-random. The difference with the other 5 basic emotions was significant (p between 0.000 and 0.027).

Non-trauma patients did report that they considered disgust to be the most physically determined and least amenable to influence, but the difference with fear and aggression was not significant, i.e. not meaningful in our sample of 71 patients.

In Question 9 of our disgust survey we intended to record the relationship between motivation and change. We wanted to follow up on our clinical observations to see if it was more difficult for the interviewed patients to change disgust than any of the other basic emotions. Table 3 documents the first result:

Changing disgust in comparison:

	N	Mean	Standard deviation	Minimum	Maximum
disgust	71	3.25	1.730	1	7
fear	71	3.94	1.874	1	7
aggression	71	4.75	1.565	1	7
grief	71	4.11	1.661	1	7
shame	71	3.30	1.525	1	7
joy	71	4.45	1.637	1	7
	fear and disgust	aggression and disgust	grief and disgust	shame and disgust	joy and disgust
Z	-2.774	-4.341	-2.687	-0.153	-4.051
Asymptotic Significance (double-sided)	0.006	0.000	0.007	0.878	0.000

Table 3.

Comparison of disgust – fear, aggression, grief, shame, joy in relation to overcoming emotions through will power / effort (Question 9 in PDQ – response analysis)

Table 3 basically confirms the statements of the previous table: in the experience of the patients disgust is a feeling that is very difficult to change. It is therefore different from the other basic emotions, except for shame. In other words, our clients experience shame to be an emotion that is just as hard to change as disgust. A comparison of the frequency distributions of disgust and shame in PDQ Question 8 (see above) shows that only 26.75% of all patients believe that disgust is mentally determined – whereas a percentage of 73.23% believes this to be the case for shame. This means for Questions 8 and 9 of the PDQ that, although disgust and shame are perceived to have different underlying causes, both are similarly difficult to change. A separate comparison of this question for the subcategories of trauma and non-trauma patients also revealed that especially the trauma patients experienced disgust and shame as very difficult to change, whereas the non-trauma patients could not confirm this, as, apart from shame and disgust, fear and grief were also considered to be similarly changeable or difficult to change, respectively. The changeability of disgust does not therefore prove to be a significant exception for non-trauma patients.

In summation, the hypothesis that disgust in patients suffering from psychological trauma is an unconscious and autonomously organised state of affect that is very hard to change through therapeutic interventions, seems verified, given that the majority of clients feel at the mercy of inner autonomous processes more so than with other basic emotions.

As disgust can combine, dominate or be in the background of any of the other basic emotions we asked the patients in Question 10 to list the combinations in which they were

aware of their feelings of disgust, i.e. which other basic emotion appears with disgust the most frequently.

The answers made clear that fear and shame combined most frequently with disgust on our empirically researched answering scale (fear – absolute 19 out of 71 = 26.8%; shame – absolute 14 out of 71 = 19.7%). By grouping together the three answer possibilities of Question 10, the frequency of fear in combination with disgust rises from approximately $\frac{1}{4}$ of all answers (26.8 % of 71) to almost $\frac{1}{3}$ of the total of answer possibilities, if the related concept panic behaviour is added in to overall reactions of fear (31.5 % of 71).

The second most frequent combination, i.e. disgust and shame, amounts to 20% and remains constant throughout.

The third most frequent combination is *anger affect* with 15.5% of 71 patients. If all three answer possibilities are taken into account and the related concept of aggressive feelings is added to the share of overall aggressive reactions, this number rises to almost $\frac{1}{3}$ (31 % of 71 patients).

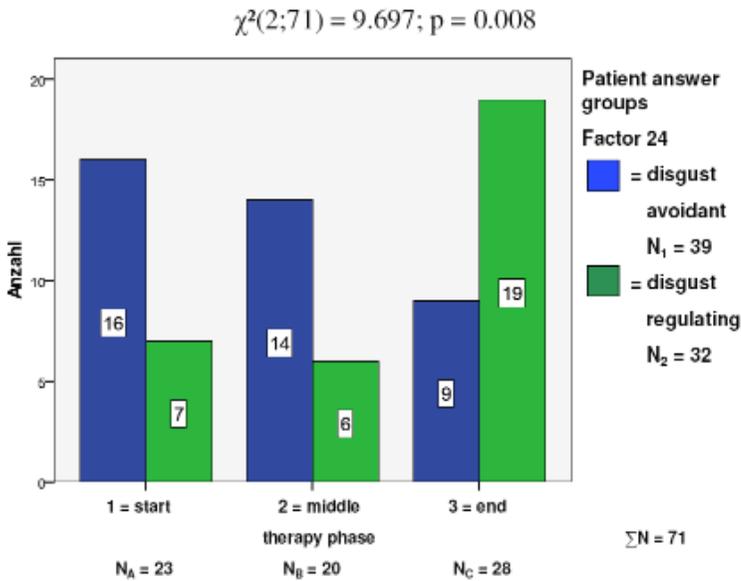
Most patients have at least two very different feelings accompanying disgust. The first and third answers they give differ significantly (Wilcoxon test for 71 patients resulted in a test value of 0.437 a significance of $p=0.018$).

From a different point of view this fear-aggression-shame hierarchy corresponds with the general behavioral organisation in traumatic situations: first, there is a tendency to flee; if that is not possible, the victim tries to fight; and if it that fails, helplessness and shame follow.

In Question 11 the patients were asked about subjective and individually different conscious behavioral reactions and strategies for acute and anticipated experiences of disgust.

More than half the patients (54.93 %) report that their behavioural patterns are very passive for disgust. They avoid disgust by planning ahead, withdrawing and fleeing. Only about $\frac{1}{4}$ of patients have very proactive and competent coping strategies (23.94 %), in which they (in relatively safe situations) consciously control their feelings and affects and choose the most favorable way of coping with the unpleasant situation. The other 25% react hesitantly, passively, or by soothing themselves – neither by fleeing nor by acting against it. We described these 32 active and passive patients who were able to cope with disgust either way (50%) “disgust regulating” and “disgust avoidant” for the purposes of our crosstabulation.

I then checked if disgust avoidance changed quantitatively during the course of therapy (see Graph 6):



Graph 6.

Disgust avoidance depending on therapy phase (Question 11 in PDQ – response analysis)

This graph shows relatively well that during therapy the level of disgust avoidance slowly decreases whilst active regulation of disgust increases. The leap in improvement between therapy phase 2 and 3 corresponds with the previously noted improvement in overcoming disgust in Question 7 of the PDQ (see above).

With another hypothesis we sought to find out if there was a possible correlation between disgust avoidance and the number of body-oriented treatment settings recorded by the therapists.

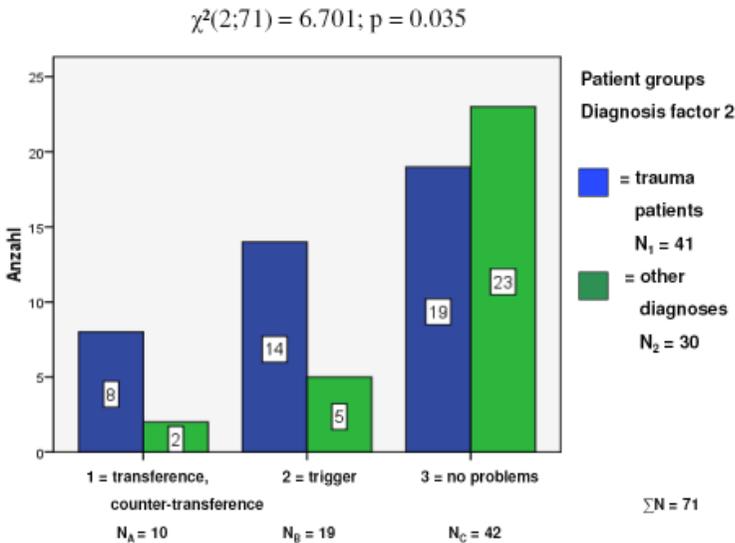
This cross tabulation confirmed our supposition that patients who avoid disgust are also considerably less accepting of physically oriented settings in therapy and that therapists intuitively tend to offer this group of patients fewer such settings ($p = 0.014$ bei $\chi^2(2; 71) = 6.053$).

The same tendency could be identified by the therapist rating (TRUS) for the dimensions *attachment and relationship blocks* in combination with the assessment dimension *implemented group and/or individual therapy settings*. The first cross tabulation revealed a significance value of $p=0.033$ ($\chi^2 2;71$, value 4.542) and the second a significance value of $p=0.024$ ($\chi^2 2;72$, value 7.477). Hypothetically speaking, the patient's subjective ability to regulate disgust could be indicative of attachment and relationship blocks and the initial reluctance to join in physical and group settings noted by the therapist. Or to put a positive spin on it: body-oriented and group settings foster attachment and relationship skills and allow the patient to overcome their avoidant behaviour as long as such settings are professionally dosed and structurally implemented.

Finally, Question 12 of the PDQ asked the patient to evaluate the experience between patient and therapist, which, admittedly, is a potential minefield.

For almost 60% (N=42, 59.15 %) the perceived disgust towards their psychotherapist does not appear to be a problem. Graph 7 (see below) further explores to what extent the disgust experienced by the patient in the therapeutic relationship could be qualitatively related to the treatment diagnosis. For this purpose I formed three groups in the therapist rating: group 1, which reported that the disgust in question “really” stemmed from the therapist. Analytically speaking, this could be partly caused by impressions of strong feelings of disgust, which constitute a hitherto unnoticeable interactive transference. On the other hand, it could also be caused by unconscious disgust in the behaviour of the therapist, which would be tantamount to a counter transference by the therapist. I therefore decided to call this group of ten patients (N=10 out of 71 = 14.08 % patients) the “transference-counter transference group”.

Nineteen more patients (N=19, 29.57 %) were grouped together in the so-called “trigger group”, as these patients reported that they very clearly experience disgust in their therapeutic relationship, but could trace it back to past transgressions, such as sexual abuse and similar negative experiences. In this case the transference could be consciously felt, even though it could not be turned off. These observations represented a cue or a trigger for a background of disgust or trauma. The third group was a grab-bag of patients without reported disgust in the patient-therapist relationship. Graph 7 differentiates among these three groups in relation to the treatment diagnosis:



Graph 7.

Disgust experienced by the behavior of the therapist (Question 12 in PDQ – response analysis)

It is possible that this composition reflects a significant correlation between the experience of psychological trauma and the disgust experienced by patients during treatment. Due to the low number of patients at N_A, however, this can only be statistically confirmed as a tendency.

Complex traumatised / dissociative patients thus tend to suffer far more from interactively experienced disgust than other psychotherapy patients. This result is hypothetically valid

for both positive and negative correlations. That means that trauma patients possibly react strongly to disgust while struggling to comprehend the transference background of it. On the other hand, trauma patients are also able to understand their experiences of disgust as triggers and are therefore increasingly less burdened by therapeutic interactions. A calculation of these phenomena in relation to therapy progress (start, middle, end) shows no frequency distribution that can be deemed significant. However, it can be phenomenologically recorded that the perception of interactive disgust is polarized at the start of therapy. The ability to perceive the trigger potential of disgust in oneself slowly grows as therapy progresses. The relatively high percentage of clients who perceived no disgust or similarly negative basic emotions probably means that the patients suppress or try to suppress their contradictory feelings unconsciously or out of a need for harmony at the start of therapy.

In conclusion, the following statistical calculations were obtained by testing the hypotheses between the therapist rating (TRUS), the Dresden Body Image Questionnaire (DKB-35 of Pöhlmann, Thiel, Joraschky, 2008) and the Questionnaire for Dissociative Disorders (FDS-20 by Freyberger, Spitzer, Stieglitz, 2005).

A comparison of the therapy course (start, middle, end) and the attachment and relationship blocks noted by the therapists showed that this interactive rejection continued to decrease as the therapy progressed, whilst the focus on contact, support and personal individual engagement steadily increased.

Other rating comparisons also confirmed this inherent treatment logic as patients were, for example, seen to be more content and better socially integrated (work, family, friends) at the end of therapy. Furthermore, patients who showed the biggest strides in improvement were also those with experiences of long-term group therapy (see also Vogt, 2004, 2007 a).

In a secondary finding we used the Dresden Body Image Questionnaire (DKB-35 by Joraschky and Pöhlmann, 2008) to find out to what extent the rating result for psychosomatic complaints corresponded with the average Dresden body image profile.

A cross tabulation between the Dresden Body Image results, a cut-off value of 3.2 and a therapy rating of very conspicuous vs. unclear psychosomatic patients showed a significant difference between these two conspicuous groups and unclear to inconspicuous groups ($p = 0.047$ at $\chi^2(2; 57) = 3.932$). This correlation, therefore, validates the rating to some extent. Patients with severe psychosomatic symptoms in therapy generally have a more distorted body image than other people.

A comparison of patients suffering from psychological trauma versus other diagnostic groups in DKB-35 and FDS-20 revealed a significant difference for both diagnostic materials regarding the aforementioned median group values. In the DKB-35, trauma patients were clearly less interested in establishing physical contact on the physical contact scale. On the conversion scale in the FDS-20 there were conspicuously more physical symptoms ($p = 0.017$ and 0.003 for $N=57$).

The FDS-20 revealed a further interesting secondary finding. We were able to identify a differential diagnosis with a meaningful value between trauma patients and other diagnostic groups both for the screening criterion $> 3 \times 30$ points and the cut-off value of ≥ 300 points with the 20 FDS questions. These are useful orientation points for our clinical work, as we basically cannot expect a higher hit quote in dissociation research.

A general problem with all the dissociation questionnaires known to us is that essentially they only become sufficiently effective from the middle phase of therapy onwards, since subjective dissociation perception only increases from that point onwards. After all, the

fear of becoming aware of complex dissociative trauma symptoms (see Van der Hart et. al., 2008) only decreases with increased trust in the psychotherapist, therapy comparisons as part of group therapy and/or personally experienced therapy progress. It is not easy to experience both *the sensitivity for and defense against* dissociative symptoms with such questionnaires.

2. Summary of the main results

Using a pilot study with a self-developed questionnaire to further investigate the feeling of disgust (PDQ) in addition to the Dresden Body Image Questionnaire (DKB-35 by Pöhlmann, Thiel, Joraschky, 2008) and the questionnaire for dissociative symptoms (FDS-20 of Freyberger, Spitzer, Stieglitz, 2005) 71 patients of an outpatient psychotherapy practice were interviewed. Their answers revealed interesting new research results in relation to the experience and overcoming disgust.

All patient groups appear to have problems mentalizing their feelings of disgust, which can only be overcome during therapy. The overall patient group describes disgusting touch and assaults, smells and views of repelling sights as particularly disconcerting.

It is striking to note that survival of sexual violence, abuse and harassment inside the family of origin are considered to be especially disgusting and difficult to overcome for the majority of patients suffering from psychological trauma. It is illustrative that these gruesome experiences are frequently completely forgotten due to the stress they exert. They are therefore only recalled within the safe framework of the therapeutic setting. Yet for another smaller group of patients it is impossible to banish their memories of the sexual violence they experienced; they suffer under the continuing duress of these pulsating emotions.

The majority of complex traumatised/dissociative patients who were mostly harmed in early childhood report clear psychosomatic complaints that persist for longer periods of time during the therapy and in the questionnaire responses.

It is shown that in their subjective experience, patients suffering from psychological trauma in particular have more difficulties overcoming disgust than other patient groups. This significant result and its comparative difference from how other basic emotions are overcome indicate that disgust may have a central role in determining and assessing successful treatment of psychological trauma. Even more meaningful is the fact that psychotherapy patients do not tend to reflect adequately on the background to their feelings of disgust at the beginning of therapy. Therapeutically speaking, the issue of disgust only emerges in the therapeutic relationship with the therapist. However indirect and encoded, disgust partly comes to the fore in a generalised defensive mechanism against body-oriented and group settings. Thus, disgust can function as an indicator of a traumatic event in addition to forecasting the possibility or impossibility of experimental body-oriented individual and group settings. Disgust is subjectively seen as highly physiological in origin and – together with shame - considered to be extremely difficult to change according to almost all clients.

According to our research results, the ability to regulate disgust only starts to grow in the final therapy phase, which is after trauma exposition work and voluntary dual settings and group therapy with body-oriented settings that are conducted in our practice.

Significant scale ratings with DBK-35 and the FDS-20 underline the fact that determining psychosomatic and dissociative symptoms and a positive change in body image structures should receive more attention in complex traumatized and dissociative

patients than may have been the case up to now. All three questionnaires generally confirm the close links among disgust, psychological trauma, distorted body images and dissociative symptoms. A continuation of the research approach would be desirable in this case.

3. Questionnaire for the pilot study

The Pilot Disgust Questionnaire (PDQ) was designed for the purpose of research. It is shown here so that colleagues can better understand and assess these partly pioneering new insights for themselves. A pilot study always aims to prompt further research on its subject. A scientific research plan, for example, could help to validate items of the questionnaire, objectify raters, and investigate samples in broader and more varied terms.

I am aware of the disadvantages of a pilot study, but together with DP Irina Vogt, I wanted to press ahead with this topic, as the issue of diagnosing and treating disgust in complex traumatised patients became ever more important in our daily work. We also wanted to encourage our colleagues to become involved in this topic. Nevertheless, we hope our results and the questionnaire we hereby make available will be accorded the usual professional respect.

The response analysis as well as the therapist rating of the research sample (TRUS) can be requested without much ado from the author. We only ask any researchers who wish to make use of our material or parts thereof to cite the source with the necessary precision and to briefly request permission via email. Obviously my wife and I would be delighted at any continuation of this practice-oriented investigation and any interest in our approach. Our first objective would therefore be to support you as straightforwardly as possible.

3.1 The pilot disgust questionnaire (PDQ)

Research questionnaire of the Trauma Institute Leipzig on the topic of disgust (PDQ – pilot disgust questionnaire)

Dear client,

We would hereby like to ask you to answer these questions as openly and truthfully as possible. All your answers will be treated with the strictest confidence and the results will be made available to you anonymously as part of a pilot study.

1.) How do you personally understand disgust? Please tell us briefly your own personal definition of the term or a personal description or list us some phenomena, etc. (3-5 lines).

I think disgust is:

.....

2.) Which experiences were particularly disgusting? Please describe up to three significant experiences of disgust (individual incident or persistent influences; please, if possible, tell us your age – if there isn't enough space, use an extra page!)

1)

(Age?):.....

3.) Which feelings of disgust had you forgotten about or repressed for a long period of time? (please remain brief) – But you always knew that they had taken place or that you had experienced them?

1).....

4.) Which feelings/experiences of disgust were you never able to forget? (please remain brief) – because they were never really banished from your consciousness and continued to live on in nightmares, daydreams, thoughts, etc?

1).....

5.) Which experiences of disgust reemerged only during the process of therapy? (having been completely forgotten after the incident/events and having been only rediscovered because of the trauma exposition? Aha-effect)

1).....

6.) Which experiences of disgust had you not known about until you started therapy? (only discovered thanks to trauma exposition – surprise effect)

1).....

7.) Please rank these emotions as to how difficult you find it to cope with them. Please use each ranking only once, even if this is difficult. Now rank the following six emotions: great fear, strong aggression, deep grief, strong disgust, deep shame, great emptiness from 1 to 6.

1. In general still easiest to cope with:.....

2. Slightly more difficult:.....

3. Even more difficult:.....

4. Much more difficult:.....

5. Hardly able to cope with:.....

6. Almost impossible to cope with:.....

8.) Which feeling is generally more physically and which feeling more mentally fixated? Please use a 7-point scale to assess each feeling! (1 cross per line)
(The 7-point scale ranges from -3 to +3 for the basic emotions of fear, aggression, grief, disgust, shame, and joy. The Excel table used in the questionnaire can unfortunately not be shown here for reasons of space.)

9.) To what extent can you change these feelings by willpower alone?
(1 cross per line)
(The 7-point scale ranges from -3 to +3 for the basic emotions of fear, aggression, grief, disgust, shame, and joy. The Excel table used in the questionnaire can unfortunately not be shown here for reasons of space.)

10.) In which hierarchical combinations do feelings of disgust appear for you? (E.g. disgust with fear / panic / shame, aggression / anger / emptiness, grief / depression and other combinations)

Please use 3 situations as an example (different or similar combinations are allowed)

- 1.) Situation: disgust with – eg. when:.....
- 2.) Situation: disgust with – eg. when:.....
- 3.) Situation: disgust with – eg. when:.....

11.) How do you deal with feelings, memories or situations of disgust on an everyday basis?

- 1.) I deal with disgusting situations by.....

12.) Have you ever felt disgust in relation to your therapist? If so, which therapy situations, e.g. a glance, gesture, facial look, language, behavior, etc, did you find especially disgusting? (By providing this feedback you help your therapist. We are aware that during therapy often contrasting situations arise, etc. Please describe up to 3 situations):

- 1) Situation:

Thank you for participating in this difficult subject. These confidential results will be made available anonymously in our pilot research study!

DP Irina Vogt Dr. Ralf Vogt Trauma-Institut-Leipzig, 2009

(This pilot disgust questionnaire was revised three times thanks to valuable feedback from clients. For reasons of space the actual answer fields have been minimized)

BIOGRAPHY

Dr. Ralf Vogt is a psychotraumatologist, psychoanalyst, family therapist, body psychotherapist, individual and group therapist. He has been working in private practice since 1992. For the past 15 years he has been working on his own therapy model SPIM-20-CT together with his wife, DP Irina Vogt. The latest version SPIM-30-CT is in progress. Together they direct the training curricular at the Trauma-Institute-Leipzig which includes workshops and seminars by renowned international clinicians. They organize biannual international conferences regarding the field of complex trauma and dissociation. Dr. Ralf Vogt has published various papers and books on trauma and dissociation in German and English. He is a member of DeGPT, ESTD, ISSTD (Fellow Award) and on the board of directors of the ISSTD.

Email: info@ralf-vogt.com. Website: www.ralf-vogt.com/

REFERENCES

- Clauß, G., Ebner, H. (1974). Grundlagen der Statistik. Berlin: Volk und Wissen
- Freyberger, H.J., Spitzer, C., Stieglitz, R.D. (2005). FDS-Fragebogen zu Dissoziativen Symptomen.
- Krause, R. (2006). Der eklige Körper in der Analyse. In Z.: AKJP (Analytische Kinder- und Jugendlichen-Psychotherapie. H 129, Jg. 1/2006, S. 7-23.
- Lienert, G. A. (1969). Testaufbau und Testanalyse. Weinheim: Beltz. 3. Aufl.
- Lohse, H., Ludwig, R., Röhr, M. (1986). Statistische Verfahren für Psychologen, Pädagogen und Soziologen. Berlin: Volk und Wissen, 2. Aufl.
- Pöhlmann, K., Thiel, P., Joraschky, P. (2008): Das Körperbild von Essgestörten Selbstbeschreibungen auf der Basis des Dresdner Körperbildfragebogens. In P. Joraschky, H. Lausberg u. K. Pöhlmann (Hrsg.): Körperorientierte Diagnostik und Psychotherapie bei Essstörungen. Gießen: Psychosozial-Verlag.
- Van der Hart, O., Nijenhuis, E., Steele, K. (2008). Das verfolgte Selbst. Paderborn: Junfermann.
- Vogt, R. (2004). Beseelbare Therapieobjekte. Strukturelle Handlungsinszenierungen in einer körper- und traumaorientierten Psychotherapie. Gießen: Psychosozial-Verlag.
- Vogt, R. (2007). Psychotrauma, State, Setting. Psychoanalytisch-handlungsaktives Modell zur Behandlung von Komplex-Traumatisierten u. a. Störungen (SPIM-20-KT). Gießen: Psychosozial-Verlag .
- Vogt, R. (2007). Handout-Manual SPIM-20-KT. Eigenverlag: Leipzig Trauma- und körperorientiertes Einzel- und Gruppentherapiekonzept mit handlungsaktiver analytischer wie verhaltenstherapeutischer Ausrichtung.
- Vogt, R. (2008). Körperpotenziale in der traumaorientierten Psychotherapie. Aktuelle Trends in körperorientierter Psychotraumatologie, Hirnforschung und Bewegungswissenschaften. Gießen: Psychosozial Verlag.
- Vogt, R. (2008). Praxis einer körper- und traumaorientierten Psychotherapie unter Berücksichtigung besonderer Settings für Anorexia-Nervosa-Patienten. In: Joraschky, P.; Lausberg, H.; Pöhlmann, K. (Hrsg.): Körperorientierte Diagnostik und Psychotherapie bei Essstörungen. Gießen: Psychosozial Verlag.
- Vogt, R. (2010.). Ekel als Folge traumatischer Erfahrungen. Gießen: Psychosozial Verlag.
- Vogt, R. (2012). Täterintrojekte - Diagnostische und therapeutische Handlungsmodelle für dissoziative Strukturen. Kröning: Asanger Verlag.
- Vogt, R. (Ed. In preparation). Perpetrator Introjects – Diagnostic and Therapeutic Treatment Models for Dissociative Structures. Kröning: Asanger Verlag.

SELECTED BOOKS

- Vogt, R. (2006). “Beseelbare” Therapeutic Objects. Psychoanalytic interactional approach in a body- and trauma-oriented psychotherapy. Gießen: Psychosozial-Verlag.
- Vogt, R. (2008). Psychotrauma, State, Setting. Psychoanalytical-Action-Related Model for a Treatment of Complexly Traumatized Patients. Gießen: Psychosozial-Verlag.
- Vogt, R. (Ed. In preparation): Perpetrator Introjects – Diagnostic and Therapeutic Treatment Models for Dissociative Structures. Kröning: Asanger Verlag.

INTERNATIONAL BODY PSYCHOTHERAPY JOURNAL

THE ART AND SCIENCE OF SOMATIC PRAXIS

(Incorporating US Association for Body Psychotherapy Journal)

volume eleven ● number one ● spring 2012

TABLE OF CONTENTS:

4 Editorial

Jacqueline A. Carleton, PhD

8 The Body: Common Ground

Katy Swafford, PhD, President, USABP

9 Body Psychotherapy: The Third Developmental Phase

Lidy Evertsen, President, EABP

10 Panta Rei

Joop Valstar, Former President, EABP

ARTICLES

12 The Relational Turn and Body-Psychotherapy

**IV. Gliding on the Strings that Connect Us:
Resonance in Relational Body Psychotherapy**

Asaf Rolef Ben-Shahar

25 From Hopeless Solitude to the Sense of Being-With:

Functions and Dysfunctions of Mirror Neurons in Post Traumatic Syndromes

Maurizio Stupiggia

41 Anxiety and Panic in Reichian Analysis

Genovino Ferri

51 Forming an Embodied Life:

The Difference between Being Bodied and Forming an Embodied Life

Stanley Keleman

57 Organismic Self-Regulation in Kurt Goldstein's Holistic Approach

Luigi Corsi

66 When the Therapist is Aroused:

Sexual Feelings in the Therapy Room

Merete Holm Brantbjerg

72 What Disgust Means for Complex Traumatized / Dissociative Patients

A Pilot Study from an Outpatient Practice

Ralf Vogt

EUROPEAN
ASSOCIATION FOR
BODY-
PSYCHOTHERAPY



United States Association for
Body Psychotherapy