Scientific Research Publishing

Journal of Biosciences and Medicines, 2026, 14(9), 264-277
https://www.scirp.org/journal/jbm
ISSN Online: 2327-509X
ISSN Print: 2327-5081

Self-Disgust in Colorectal Cancer Patients with an Ostomy: A Narrative Review

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How to cite this paper: Zhang, H.Y. and Gong, A.P. (2026) Self-Disgust in Colorectal Cancer Patients with an Ostomy: A Narrative Review. *Journal of Biosciences and Medicines*, **14**, 264-277.
https://doi.org/10.4236/jbm.2026.149015

Received: August 12, 2026
Accepted: September 12, 2026
Published: September 15, 2026

Abstract

This narrative review provides a comprehensive synthesis of domestic and international research on self-disgust among colorectal cancer patients with an ostomy, covering its conceptualization, assessment tools, influencing factors, and interventions. The review aims to enhance healthcare professionals' awareness of self-disgust in this patient population, promote patients' mental health and quality of life, and provide a reference for future related studies.

Keywords

Colorectal Cancer, Stoma, Self-Loathing, Influencing Factors, Review

1. Introduction

Colorectal cancer is one of the most common gastrointestinal malignancies in China, with incidence and mortality rates showing an upward trend year by year [1]. Surgical resection is the primary treatment method; among these patients, approximately 50% to 60% require permanent or temporary ostomy surgery due to the tumor's low location [2]. According to statistics, there are approximately 100,000 new cases of permanent ostomy in China each year, and to date, the total number of patients in this population has exceeded 1 million [3]. Although ostomy surgery saves patients' lives, it alters their original bowel habits. Patients may experience intestinal gas, fecal leakage, and unpleasant odors, which severely impact their physiological functions, body image, and social interactions, causing serious consequences for their mental health and ultimately contributing to self-disgust [4]. Self-disgust [5] refers to the intense feelings of negativity, loathing, and rejection that an individual directs toward themselves. Its core manifestations are primarily concentrated at the individual level (where the individual often views themselves as repulsive) and the behavioral level (where the individual feels

dissatisfaction and disgust toward their own habitual behaviors). Studies have shown that individuals with high levels of self-loathing are not only more prone to depression, anxiety, and borderline personality disorder, but also face an increased risk of suicide [6]; furthermore, this psychological state has a significant negative impact on the postoperative adjustment and long-term quality of life of ostomy patients [7]. Therefore, timely identification of self-disgust in colorectal cancer patients with an ostomy and implementation of effective prevention strategies are of critical importance. Based on this, the present study aims to provide a narrative review of the concept, assessment tools, research status, influencing factors, and intervention implications of self-disgust in this population, with the goal of offering a theoretical foundation for clinical nurses to identify and intervene in self-disgust among colorectal cancer patients with an ostomy, thereby promoting patients' mental health and improving their quality of life.

2. Development and Conceptualization of Self-Disgust

Disgust is a fundamental, universal human emotion with a unique evolutionary adaptive function—it protects individuals from stimuli that may carry pathogens (such as spoiled food or excrement) through aversion, avoidance, and rejection, thereby preventing disease and infection [8]. The emotion of disgust is accompanied by distinctive facial expressions (such as wrinkling the nose and drooping the corners of the mouth), behavioral manifestations (avoidance, inhibition of contact), and subjective experiences (a feeling of nausea), which clearly distinguish it from other negative emotions (such as fear and anxiety) [9]. As psychological research has deepened, scholars have recognized that the focus of aversion can extend beyond external stimuli to the individual themselves. In his theory of negative cognitions in depression, Beck [10] points out that depressed individuals' negative self-evaluations may manifest as a form of "self-dislike", and that this feeling "may develop into self-aversion". Whelton *et al.* [11] further propose that the "emotional tone of aversion" internalized during children's social development forms an "introject", becoming an internal voice of self-criticism; this process may ultimately lead individuals to develop a profound aversion toward themselves. Based on this, Powell *et al.* [12] define self-disgust as a persistent emotion of self-awareness, whose core characteristic can be summarized as "viewing the self as an object of loathing". It reflects an individual's intense dissatisfaction, hatred, and rejection of themselves, and is a profound, inward-directed emotional experience that entails a complete denial of one's self-worth. Furthermore, Powell *et al.* [12] proposed a model of the emotional schema of self-disgust, providing a systematic theoretical framework for understanding the formation and maintenance of self-disgust. According to this model, initial reactions of self-disgust may arise through cognitive evaluation processes (such as negatively evaluating one's own traits or behaviors) or through associative processes (where disgust triggered by external stimuli is evoked by aspects associated with the self). If this initial self-disgust reaction is further reinforced, it may develop into an overarching self-cognitive

framework that guides subsequent perception, attention, memory, and cognitive processes in a manner consistent with the schema, thereby enabling the schema to self-maintain. Previous studies have shown [13] that self-disgust is an important psychological factor affecting an individual's mental health; it is closely associated with emotional disorders such as anxiety and depression, and serves as a strong predictor of suicide risk. Among colorectal cancer patients with an ostomy, although research on self-loathing began relatively late, multiple studies [14] [15] have confirmed that patients experience varying degrees of aversion toward their stoma and themselves, which significantly impacts their psychosocial adaptation. Therefore, greater attention must be paid to self-disgust among colorectal cancer patients with an ostomy in order to improve their psychological well-being and quality of life.

3. Assessment Tools for Self-Disgust in Patients with Colorectal Cancer Ostomy

3.1. Self-Disgust Scale, SDS

The SDS was developed by Overton *et al.* [16] based on self-disgust theory to measure levels of self-disgust among college students; it is the first instrument to systematically measure self-disgust. The scale consists of 18 items across three dimensions: self-disgust, behavioral disgust, and general self-concept. It includes six neutral filler items, which are used to balance the negative statements of the other items and are not included in the total score. The scale uses a 7-point Likert scale for scoring, with a total score range of 12 to 84; a higher score indicates a higher level of self-disgust. Testing revealed that the SDS has a Cronbach's alpha coefficient of 0.91. Moncrieff-Boyd *et al.* [17] revised the SDS to create the Self-Disgust Scale Revised Version (SDS-R), designed to more accurately measure individuals' feelings of disgust and aversion toward their bodies and selves, as well as low levels of self-acceptance. In China, Xiong *et al.* [18] completed the Chinese adaptation of the SDS, creating the Chinese Version of the Self-Disgust Scale (SDS-C), which has demonstrated good reliability and validity in a sample of patients with depression. The introduction of this Chinese version of the scale provides an important tool for conducting research on self-disgust in China. To date, the SDS has not undergone formal validation specifically in colorectal cancer patients with an ostomy, and further verification is warranted.

3.2. Questionnaire for the Assessment of Self-Disgust, QASD

In response to the limitations of the SDS regarding factor construction methods and sample composition [19], Schienle *et al.* [20] developed the QASD in 2014. This self-report scale consists of two dimensions: self-disgust (9 items, assessing negative evaluations of one's own appearance and personality) and behavioral disgust (5 items, assessing negative evaluations of one's own behavior), for a total of 14 items. All items are scored using a 5-point Likert scale (0 = "Strongly Disagree" to 4 = "Strongly Agree"), with a total score ranging from 0 to 56; a higher score

indicates a higher level of self-disgust. The Cronbach's alpha coefficients for personal disgust and behavioral disgust are 0.92 and 0.84, respectively, indicating that the scale possesses good reliability and validity. In 2016, Jin *et al.* [21] adapted the QASD into Chinese, creating the Chinese version of the Questionnaire for the Assessment of Self-Disgust (QASD), and administered the self-disgust assessment to 201 patients with depression. The results showed that the scale had a Cronbach's alpha coefficient of 0.895, a test-retest reliability of 0.813, and a content validity index of 0.931, indicating that the Chinese version of the QASD possesses good reliability and validity. The QASD has been applied to various chronic disease populations, including colorectal cancer patients with an ostomy [15], breast cancer patients [22], patients with diabetes [23], and patients with gynecological malignancies [24]. Specifically, in a study by Qin [25] on patients with permanent ostomies, Cronbach's alpha was 0.87; in a study by Liao *et al.* [26] on patients with malignant lymphoma, Cronbach's alpha was 0.94. These data indicate that the QASD exhibits good internal consistency across different patient populations and serves as a reliable tool for assessing levels of self-disgust in patients with chronic diseases, including those with an ostomy.

3.3. Colostomy Disgust Scale, CDS

Jin *et al.* [27] developed a stoma aversion scale specifically for patients with colorectal cancer who have undergone stoma creation. The scale consists of 22 items across two dimensions: basic aversion (13 items) and interpersonal aversion (9 items). It uses a 5-point Likert scale, with "strongly disagree" scored as 1 and "strongly agree" as 5. The total score ranges from 22 to 110; a higher score indicates a greater degree of stoma aversion in the patient. Cronbach's alpha for the two dimensions are 0.94 and 0.91, respectively, indicating that the scale has high internal consistency. The CDS was developed and validated specifically in colorectal cancer patients with an ostomy, with confirmatory factor analysis supporting its two-factor structure and demonstrating good construct validity in this population. It is worth noting that the CDS measures "colostomy disgust"—a disgust response directed towards the external stimulus of the stoma itself—rather than "self-disgust", which is directed towards the self. However, among patients with a stoma, the persistent experience of disgust towards the stoma may gradually become internalized as self-directed negation, thereby forming a trajectory from "colostomy disgust" to "self-disgust". Therefore, the CDS can serve as a complementary tool for assessing self-disgust in colorectal cancer patients with an ostomy, and may be used in conjunction with the SDS or QASD to comprehensively capture different facets of disgust-related emotions in this population.

3.4. Edinburgh Self-Disgust Scale, ESDS

Alanazi [28] developed the ESDS in his doctoral dissertation, aiming to address the limitations of existing self-disgust measures in capturing the full scope of the construct. The scale comprises five dimensions—body shape, self-concept, unac-

ceptable behaviour, treatment of others, and past experience-and demonstrated satisfactory reliability and validity in both non-clinical samples (alpha = 0.944) and clinically depressed samples (alpha = 0.942) in Saudi Arabia. Confirmatory factor analysis supported the five-factor structure, with the total scale Cronbach's alpha ranging from 0.94 to 0.95. However, the scale has currently only been validated in Saudi Arabian populations, and no Chinese version is available. Its applicability to colorectal cancer patients with an ostomy in China requires further investigation.

4. Influencing Factors of Self-Disgust in Patients with Colorectal Cancer Ostomy

4.1. Related to Disease and Treatment

Disease and treatment-related factors play an important role in the development of self-disgust among colorectal cancer patients with an ostomy.

1) Stoma complications. A survey by Yang *et al.* [29] of 221 patients with mid-to-late-stage low rectal cancer who had undergone stoma creation found that patients with stoma complications exhibited higher levels of self-disgust. Common complications such as peristomal dermatitis, stoma stenosis, stoma prolapse, and leakage not only cause physical discomfort and pain but also lead to intense feelings of disgust toward the stoma itself.

2) Number of comorbid chronic conditions. Research by Gao [30] *et al.* indicates that ostomates with multiple chronic conditions must not only cope with the physical and psychological challenges posed by the ostomy but also manage their other underlying diseases. This multiple stress significantly increases patients' psychological burden, thereby exacerbating self-disgust.

3) Type of ostomy. Şengül *et al.* [7] found that ileostomy patients had significantly higher self-disgust sensitivity scores than colostomy patients. This difference may be related to the physiological characteristics of the two types of stomas: ileostomies are located in the lower right abdomen; their output is thinner and rich in digestive enzymes, requiring patients to empty their ostomy bags more frequently; and the output is more corrosive, making it more likely to cause complications in the skin around the stoma. In contrast, colostomies are located in the lower left abdomen; their output is relatively solid, and care is relatively less demanding.

4) Time since stoma creation. Relevant studies [31] [32] have found that patients' levels of stoma-related disgust show a gradual downward trend over time, as they become increasingly accustomed to the stoma through repeated exposure to stoma-related stimuli. This adaptive change over time aligns with the habituation perspective of disgust: following repeated exposure to disgust-eliciting stimuli, individuals' sensitivity to the stimuli gradually decreases, and their emotional responses tend to subside.

5) Additionally, patients with advanced tumor stage [30], those requiring chemotherapy [29], and those who did not undergo sphincter preservation [29] tend to

report higher levels of self-disgust. These patients face a heavier treatment burden and greater depletion of psychological resources, making them more susceptible to falling into a vicious cycle of self-negation.

The aforementioned factors do not operate in isolation but rather interact with one another. Clinical nursing should implement comprehensive psychological interventions for this patient population, providing enhanced training in stoma care skills while simultaneously addressing body image concerns, treatment-related side effects, and long-term psychological support.

4.2. Demographic Factors

1) Gender. Male patients reported significantly higher levels of self-disgust than female patients in some studies [30], while other studies [31] have found the opposite pattern. Thus, the relationship between gender and self-disgust remains inconclusive. One possible mechanism for higher self-disgust in males may relate to traditional breadwinner roles and associated role disruptions [30], whereas higher self-disgust in females may be linked to greater sensitivity to body image changes [31]. However, these explanations require direct empirical validation in future studies.

2) Age. Patients of different ages exhibit varying capacities for psychological adaptation to the stoma [30]. Young and middle-aged individuals, who are typically in the midst of career development, marriage, and active social lives, face more intense role conflicts and social pressures due to the stoma, and consequently tend to report higher levels of self-disgust.

3) Educational level. Patients with higher educational attainment possess stronger abilities to access, comprehend, and integrate health-related information [30]. They are more capable of proactively seeking knowledge about stoma care through multiple channels and rationally understanding the necessity and meaning of the stoma. In contrast, patients with lower educational levels tend to receive information passively and are more likely to misinterpret the stoma as a symbol of "defect" or "otherness", thereby generating stronger self-negation.

4) Occupational status. A qualitative study by Pang *et al.* [14] found that patients often experienced a sense of disconnection from society due to their inability to return to work, and the loss of their professional role directly undermined their self-identity, leading to considerable self-disgust.

In summary, demographic factors—including gender, age, educational level, and occupational status—are associated with the level of self-disgust in colorectal cancer patients with an ostomy through multiple pathways. Although most of these factors are non-modifiable individual characteristics, their underlying mechanisms provide important evidence for clinical identification of high-risk populations and the development of stratified intervention strategies.

4.3. Psychological and Social Factors

1) Stoma acceptance. Patients with higher levels of stoma acceptance are more

likely to embrace the self with a stoma, thereby showing lower levels of self-disgust [15].

2) Stoma care self-efficacy. Patients with lower stoma care self-efficacy are more prone to feelings of frustration and incompetence due to difficulties in stoma care, which further reinforces self-negation.

3) Self-compassion. Studies have shown that self-compassion is significantly negatively correlated with stoma-related disgust, with experiential avoidance partially mediating this relationship [33], suggesting that adopting a tolerant attitude toward one's suffering and reducing avoidance of negative experiences can effectively decrease disgust levels.

4) Disgust sensitivity. Patients with higher disgust sensitivity are more susceptible to stoma-related visual, olfactory, and tactile stimuli, thereby triggering stronger negative emotional responses [33].

5) Level of spiritual health. Patients with higher levels of spiritual health are able to view their illness from a broader perspective, perceiving the stoma as a "treatment modality" rather than a "physical defect", thus reducing self-negation [29].

6) Negative emotions such as anxiety and depression. These emotions share reciprocal pathways with self-disgust [34], directly exacerbating psychological distress and further intensifying self-disgust.

7) Social support. Multiple studies [29] [30] have confirmed that social support is significantly negatively correlated with self-disgust. Support from family, friends, and fellow patients can help patients rebuild their confidence in coping with the illness, redefine themselves, and thereby reduce self-disgust.

In summary, clinical interventions should adopt a multidimensional approach encompassing the enhancement of stoma acceptance, self-efficacy, and self-compassion, the strengthening of social support, and the implementation of disgust desensitization training, while guiding patients to actively cope with their illness and delivering stratified interventions to reduce patients' levels of self-disgust.

5. Intervention Strategies for Reducing Self-Disgust in Patients with Colorectal Cancer Ostomy

Current evidence indicates that no specific intervention studies directly targeting self-disgust in colorectal cancer patients with an ostomy have been reported to date. Therefore, the interventions reviewed below constitute indirect evidence based on related outcomes such as stigma, acceptance, or quality of life, which may offer valuable insights for future interventions directly targeting self-disgust.

5.1. Acceptance and Commitment Therapy, ACT

ACT [35] is a psychological intervention that aims to improve mental health by helping patients accept rather than avoid unpleasant internal experiences, while committing to actions aligned with their personal values. It comprises six core therapeutic processes: acceptance, cognitive defusion, present-moment awareness, self-as-context, values clarification, and committed action. Shi *et al.* [36] de-

livered a 6-week ACT intervention to patients with colorectal cancer, using a combination of individual and group sessions. The study found that integrating ACT into routine stoma care enhanced patients' self-efficacy, psychological resilience, and quality of life, while also reducing the incidence of stoma-related complications. These findings suggest that ACT is a valuable supportive therapeutic approach in stoma care. Accordingly, future interventions could employ ACT to address self-disgust in colorectal cancer patients with an ostomy. Specifically, through acceptance and cognitive defusion techniques, patients can be helped to recognize negative thoughts such as "I am disgusting" or "I am repulsive", and to understand these as mere thoughts rather than objective facts, thereby weakening the cognitive foundation of self-disgust. Mindfulness practices can guide patients to engage with present-moment experiences with awareness, reducing experiential avoidance behaviors—such as avoiding social interactions or touching the stoma due to disgust—and enabling them to learn to coexist with the stoma. Through values clarification and committed action, patients can be supported to explore life values that transcend their illness identity, thereby challenging the stoma-centered negative self-definition, and to develop corresponding concrete action plans. By acting in accordance with their values, patients can rebuild their sense of self-worth and meaning in life, ultimately reducing self-disgust at its core.

5.2. Narrative Therapy

Narrative therapy [37] helps patients reshape their negative perceptions of themselves and their illness by re-authoring and reinterpreting their life stories. Its core techniques include externalization, identification of unique outcomes, re-authoring, de-pathologization, and de-labeling. Wang *et al.* [38] established an intervention group in which patients with colorectal cancer engaged in narrative sharing, self-compassionate expressive writing, and reflective discussions. These measures effectively alleviated patients' negative emotional states and subsequently improved their sleep quality and quality of life. Multiple studies [39] [40] have also confirmed the benefits of narrative therapy for patients' physical and mental well-being. Narrative therapy enables patients to reintegrate the "self with a stoma" into a coherent life narrative, helping them break the absolutism of self-disgust and reconstruct their sense of self-worth. This provides a feasible intervention pathway for reducing self-disgust in colorectal cancer patients with an ostomy. Future research may draw upon established standardized narrative therapy protocols, using self-disgust as a primary outcome measure in randomized controlled trials to validate its effectiveness in alleviating self-disgust.

5.3. Mindfulness-Based Therapy

Mindfulness therapy [41] is a psychological intervention centered on mindfulness. Its core principle is to guide patients to focus their attention on present-moment physical and mental experiences (such as breathing or bodily sensations), thereby breaking the cycle of ruminating on past traumatic events and excessive worry about future uncertainties, with the aim of alleviating anxiety. Its primary inter-

vention methods include mindfulness meditation, body scan, mindful walking, and breathing exercises. Hu *et al.* [42] conducted an 8-week RCT in colorectal cancer patients with an ostomy and found that mindfulness-based stress reduction training combined with routine stoma nursing could reduce stigma and improve quality of life. The unique value of mindfulness therapy in addressing self-disgust lies in the fact that it does not directly combat or eliminate this negative emotion; rather, through a series of mindfulness practices, it fundamentally transforms the individual's relationship with self-disgust, helping to break the negative thought cycle associated with it.

5.4. Cognitive Behavioral Therapy, CBT

The core tenet of CBT [43] is that an individual's emotions and behaviors are not directly determined by events themselves, but are shaped by their cognition and interpretation of those events. Based on this principle, CBT alleviates psychological distress by correcting maladaptive cognitive and behavioral patterns. For colorectal cancer patients with an ostomy, CBT can reduce self-disgust through the following approaches [38]: 1) Identifying and correcting maladaptive cognitions. For example, by distributing ostomy-related informational booklets, guiding patients to gradually adapt to the ostomy care process, and teaching patients to identify erroneous thought patterns; 2) Behavioral training. For example, instructing patients in progressive muscle relaxation and distraction techniques, and teaching ostomy bag replacement skills; 3) Cognitive restructuring. Patients with similar experiences can be brought together so that, through mutual understanding and acceptance fostered by group interaction, they can share their perspectives on the ostomy with one another, thereby helping them establish accurate cognitions. 4) Reinforcing positive cognitions. Encourage patients to express their perceptions of the stoma, and affirm and praise positive cognitions.

5.5. Social Support Interventions

Social support is an important protective factor against self-disgust in colorectal cancer patients with an ostomy. Among its various forms, peer support is one of the most effective. Patients who have successfully adapted to life with a stoma can be organized into support groups with newer patients, sharing experiences in stoma care, emotional feelings, and coping strategies through face-to-face conversations, telephone calls, and WeChat interactions. This approach helps reduce feelings of loneliness and exclusion, while allowing patients to gain confidence from the successful adaptation of others [44]. In addition, family support is equally indispensable. Training programs for patients and their family members in stoma care skills can enhance family members' understanding of the stoma and their involvement in care, thereby helping patients rebuild their family role identity [45].

6. Summary

Self-disgust exerts a detrimental impact on the physical and mental health and

quality of life of colorectal cancer patients with an ostomy. Although current studies have identified commonly used assessment instruments and major influencing factors of self-disgust, research on self-disgust in this population remains insufficient both domestically and internationally. Several limitations persist: 1) limited representativeness of study samples; 2) a lack of specific assessment tools validated in this population; 3) an absence of individualized interventions and direct evidence from intervention studies. Future research should conduct multicenter, large-sample studies, refine assessment instruments, further explore the influencing factors and underlying mechanisms of self-disgust, and develop personalized and targeted intervention protocols. Incorporating self-disgust screening into routine psychological assessment for colorectal cancer patients with an ostomy may facilitate early identification of at-risk individuals and enable precision-based interventions, ultimately promoting the physical and mental health and well-being of colorectal cancer patients with an ostomy.

Acknowledgements

The author would like to thank Supervisor Gong Aiping for her valuable guidance on this manuscript. No funding was received for this review.

Author Contributions

Conceptualization, Haiying Zhang and Aiping Gong; methodology, Haiying Zhang; formal analysis, Haiying Zhang; data curation, Haiying Zhang; writing-original draft preparation, Haiying Zhang; writing-review and editing, Haiying Zhang and Aiping Gong; supervision, Aiping Gong. All authors have read and agreed to the published version of the manuscript.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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