



RESEARCH ARTICLE

Childhood Trauma and Neglect as Predictors of Body Dysmorphic Symptoms among Gay Men

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Abstract

Body Dysmorphic Symptoms is increasingly recognized as a significant mental health condition associated with body image dissatisfaction and psychological distress. However, empirical research examining the impact of adverse childhood experiences, particularly among sexual minority populations, remains limited. This study aimed to examine whether childhood trauma and child neglect predict body dysmorphic symptoms among gay men. It was hypothesized that both variables would significantly contribute to body dysmorphic symptoms. This study employed a quantitative correlational design involving 202 participants recruited through purposive sampling. Standardized psychological instruments were used to assess body dysmorphic symptoms, childhood trauma, and child neglect. Data were analyzed using Spearman correlation and multiple regression analysis. Results indicated that childhood trauma was positively correlated with body dysmorphic symptoms ($r = 0.185, p < 0.01$), while child neglect showed a stronger correlation ($r = 0.379, p < 0.01$). Multiple regression analysis further demonstrated that both variables significantly predicted body dysmorphic symptoms ($R = 0.460, p < 0.01$), accounting for 21.2% of the variance. These findings emphasize the psychological impact of early adverse experiences on body image disturbances and highlight the importance of trauma-informed mental health interventions for sexual minority populations.

Keyword: Body dysmorphic; child neglect; childhood trauma; gay men

INTRODUCTION

Body dysmorphic symptoms are psychological symptoms characterized by an intense preoccupation with perceived defects or flaws in physical appearance that are either unnoticeable or appear only slight to others (Brennan et al., 2023; Hejjeh et al., 2025). These symptoms are typically accompanied by compulsive behaviors, such as repeatedly checking one's appearance in mirrors, engaging in excessive grooming, comparing one's appearance with that of others (appearance comparison), or seeking reassurance from others about one's physical appearance (Alomari & Makhdoom, 2019; APA, 2013). Although not all individuals experiencing body dysmorphic symptoms meet the diagnostic criteria for Body Dysmorphic Disorder (BDD), elevated levels of these symptoms have been associated with impaired social functioning, anxiety, depression, reduced quality of life, and an increased risk of suicide (Didie et al., 2012; Malik et al., 2021). Body dysmorphic symptoms has become an

important concern in clinical psychology due to its strong association with psychological dysfunction, including depression, anxiety disorders, social avoidance, and suicidal ideation. Individuals with Body dysmorphic symptoms frequently experience significant impairments in social functioning, occupational performance, and interpersonal relationships. Research also demonstrates that body dissatisfaction is strongly associated with reduced psychological well-being, lower sexual satisfaction, and increased emotional distress (Blashill et al., 2016; Oshana et al., 2020; Tiggemann et al., 2007)

Previous research consistently indicates that gay men constitute a population at heightened risk for body dysmorphic symptoms. Compared with heterosexual men, they report significantly greater body dissatisfaction, heightened appearance-related concerns, larger discrepancies between perceived and ideal body characteristics, and more severe body image disturbance. These findings suggest that gay men are more likely to evaluate themselves against culturally idealized body standards, thereby increasing vulnerability to body dysmorphic symptoms (McArdle & Hill, 2009; Schmidt et al., 2022). Within sexual minority populations, particularly gay individuals, body image concerns may become more pronounced due to appearance-related social norms and cultural expectations. Certain subcultures emphasize physical attractiveness, muscularity, and youthfulness, which may increase internalized appearance standards. These pressures may contribute to increased body

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monitoring behaviors and dissatisfaction, which are known predictors of Body dysmorphic symptoms (Fabris et al., 2022; Oshana et al., 2020; Tiggemann et al., 2007).

This vulnerability can be understood through Minority Stress Theory, which posits that individuals belonging to sexual minority groups are exposed to chronic stress resulting from stigma, discrimination, prejudice, social rejection, and pressure to conceal their sexual orientation. Unlike the stress experienced by the general population, minority stress is unique to minority status and operates as a persistent and chronic stressor, thereby increasing the risk of various psychological problems (Oshana et al., 2020). (Convertino et al. (2021), found that sexual minority stress was significantly associated with greater dysmorphic concerns, disordered eating, and the use of appearance- and performance-enhancing drugs among sexual minority individuals, suggesting that minority stress contributes to increased body dysmorphic concerns. These findings indicate that social stigma, the need for social acceptance, and the tendency to engage in appearance-based social comparison may further exacerbate gay men's vulnerability to body dysmorphic symptoms. In the present study, Minority Stress Theory serves as a conceptual framework for understanding the psychosocial context underlying the study population rather than as a variable to be empirically tested.

Beyond the social stress associated with sexual minority identity, accumulating evidence suggests that traumatic experiences during childhood constitute an important developmental determinant of body image disturbances (Bödicker et al., 2022). Childhood trauma has consistently been identified as an important developmental factor associated with body dysmorphic symptoms. Childhood trauma, including experiences of abuse and neglect, may disrupt the development of a healthy self-concept and contribute to long-term body image disturbances. Early adverse experiences may contribute to body-related shame, negative self-evaluation, and maladaptive beliefs about personal worth. These psychological processes may increase sensitivity to perceived physical flaws and vulnerability to body dysmorphic symptoms. (Oliveira et al., 2024). Childhood neglect is a form of childhood maltreatment that may have long-term psychological consequences. Unlike traumatic experiences that may occur as more discrete events, childhood neglect is characterized by persistent failures to provide adequate care, which may compromise children's physical health, emotional development, and overall well-being (Dubowitz et al., 1993; Jackson et al., 2022). Such experiences may contribute to the development of negative self-schemas, characterized by beliefs that one is unworthy, unlovable, or undeserving of acceptance from others, thereby increasing reliance on external validation and self-focused attention (May et al., 2022).. Therefore, childhood trauma and child neglect may contribute to body dysmorphic symptoms through different psychological mechanisms. Examining both variables within a single research model is important for understanding their relative contributions to body dysmorphic symptoms.

Among gay men, the psychological impact of childhood trauma is unlikely to occur independently of the social context associated with belonging to a sexual minority (Nowicki et al., 2022). Experiences of childhood trauma and child neglect may increase individuals' psychological vulnerability, which may subsequently be exacerbated by experiences of discrimination, stigma, social rejection, pressure to conform to idealized body standards, and the need to gain acceptance within their social community (Frost & Meyer, 2023). These experiences may encourage

individuals to engage in social comparison, internalize unrealistic appearance ideals, and rely on physical appearance as a primary basis for self-evaluation (Barnhart et al., 2022; Brewster et al., 2017). Furthermore, (Santonnicolo et al., (2025) reported that the association between minority stress and body image problems is mediated by the internalization of appearance ideals, self-esteem, and body surveillance. This evidence provides a conceptual basis for suggesting that childhood traumatic experiences and the social pressures associated with sexual minority status may interact to increase vulnerability to body dysmorphic symptoms among gay men.

Although the association between childhood trauma and body image disturbances has been widely documented, several important research gaps remain. First, previous studies have primarily focused on specific forms of childhood maltreatment, whereas childhood neglect, a chronic form of developmental adversity, has received considerably less attention. Second, few studies have examined childhood trauma and child neglect simultaneously as predictors of body dysmorphic symptoms. Third, most existing evidence has been derived from Western populations, limiting the generalizability of findings to other sociocultural contexts, including Indonesia. Finally, research on body dysmorphic symptoms among gay men in Indonesia remains scarce, despite this population's heightened exposure to minority stressors such as stigma, discrimination, appearance-related norms, and pressure for social acceptance, which may intensify the psychological impact of childhood trauma. Therefore, investigating childhood trauma and child neglect within the psychosocial context experienced by gay men may provide a more comprehensive understanding of factors associated with body dysmorphic symptoms.

Based on these research gaps, this study aims to examine childhood trauma and child neglect as predictors of body dysmorphic symptoms among gay men in Indonesia. Minority Stress Theory serves as the conceptual framework for understanding the psychosocial context of gay men's experiences, including stigma, discrimination, appearance-related pressures, social comparison, and the need for social acceptance, but it is not tested as a variable in the proposed model. Based on previous theoretical and empirical evidence, this study hypothesizes that childhood trauma and childhood neglect are jointly associated with variance in body dysmorphic symptoms. It is also hypothesized that childhood trauma is positively associated with body dysmorphic symptoms and that childhood neglect is positively associated with body dysmorphic symptoms.

MATERIALS AND METHODS

This study employed a quantitative cross-sectional correlational design to examine the relationship between childhood trauma, childhood neglect, and body dysmorphic symptoms among gay men in Indonesia. A correlational design was considered appropriate because the primary objective of the study was to examine predictive relationships among naturally occurring psychological variables without experimental manipulation (Field, 2024; Sugiyono, 2022).

Participants and Procedure

Participants consisted of gay men living in Indonesia who reported experiences related to childhood trauma.

Participants were recruited using purposive sampling through online communities and social media platforms. The inclusion criteria required participants to (1) self-identify as gay, (2) be willing to participate voluntarily, and (3) complete the research questionnaire. This population was selected based on theoretical arguments suggesting that sexual minority individuals are more vulnerable to body image disturbances due to stigma exposure, trauma experiences, and minority stress processes (Meyer, 2003; Oshana et al., 2020).

Data were collected through an anonymous online survey using Google Forms. The survey link was disseminated through various social media platforms, including Instagram, X (formerly Twitter), Facebook, and WhatsApp, to reach eligible participants. Data were collected over a three-month period, from January to March 2026. Participation was voluntary, and all responses were collected anonymously. Online data collection was selected due to the sensitive nature of the research topic and the hidden characteristics of the population, which makes traditional sampling methods difficult to implement. Online surveys also provide anonymity that may increase honesty in responses when measuring sensitive psychological experiences (Bougie & Sekaran, 2025).

Sample size was determined using an *a priori* power analysis with G*Power 3.1.9.7, assuming a medium effect size ($f^2 = 0.15$), $\alpha = 0.05$, power = 0.80, and two predictor variables. The analysis indicated a minimum requirement of 68 participants. The final sample consisted of 202 participants, substantially exceeding the minimum requirement. This sample size is considered adequate for multiple regression analysis and provides improved statistical stability, parameter accuracy, and stronger generalizability of findings (Kelley & Maxwell, 2003).

Measures

Body Dysmorphic Symptoms

Body dysmorphic symptoms were measured using a scale developed by the researcher based on the diagnostic characteristics proposed by Phillips (2009), which emphasize three core components: appearance preoccupation, psychological distress or functional impairment, and differentiation from other psychological disorders. The scale development was guided by established conceptualizations and assessment approaches for body dysmorphic that have demonstrated satisfactory psychometric properties in previous studies. These findings provided a theoretical and psychometric foundation for the development of the present scale. The initial instrument consisted of 30 items composed of 15 favorable and 15 unfavorable statements measured using a four-point Likert scale ranging from strongly disagree to strongly agree. The use of Likert scales is recommended in psychological measurement because it allows the quantification of psychological tendencies and attitudes in a structured manner (Batterton & Hale, 2017; Joshi et al., 2015).

Item discrimination testing was conducted in two stages to ensure construct validity. In the first stage, 28 items were retained with corrected item-total correlation coefficients ranging from 0.305 to 0.570. Two items (items 3 and 15) were removed because their coefficients ranged between 0.071 and 0.097, which fell below the recommended minimum threshold of 0.30 (Bougie & Sekaran, 2025). A second analysis conducted on the remaining items indicated that all 28 items met validity criteria, with coefficients ranging from 0.307 to 0.572. Therefore, the final Body Dysmorphic Symptoms scale

consisted of 28 valid items demonstrating acceptable psychometric quality.

Childhood Trauma Questionnaire-Short Form (CTQ-SF)

Childhood trauma was measured using a scale adapted from Childhood Trauma Questionnaire-Short Form (CTQ-SF) framework developed by Bernstein et al., (2003), which is widely recognized as a reliable instrument for assessing childhood maltreatment experiences. The initial scale consisted of 25 items covering emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect dimensions. Previous research reported reliability coefficients ranging from 0.79 to 0.94, indicating strong internal consistency of the original instrument (Bernstein et al., 2003). The CTQ-SF assesses five dimensions of childhood maltreatment, namely emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. In the present study, the total CTQ-SF score was used to represent cumulative childhood trauma exposure rather than examining each subtype separately. This approach was adopted to capture the overall burden of childhood traumatic experiences, recognizing that different forms of maltreatment frequently co-occur and collectively influence psychological functioning.

Item discrimination testing in this study showed that 24 items met validity criteria with coefficients ranging from 0.309 to 0.499. One item (item 21) was removed due to a low validity coefficient of 0.138. A second stage validity analysis confirmed that all remaining items were valid, with coefficients ranging between 0.311 and 0.496. Therefore, the final trauma scale consisted of 24 valid items.

The Neglect Scale

Neglect scale was measured using a scale based on the neglect framework proposed by (Harrington et al., 2002), which conceptualizes neglect as failure to meet developmental needs including emotional, cognitive, supervisory, and physical needs.

The initial instrument consisted of 40 items. Validity testing showed that 39 items met validity criteria with coefficients ranging between 0.344 and 0.638. One item (item 2) was removed because its coefficient (0.117) did not meet the required threshold. A second validity analysis confirmed that all remaining items were valid, with coefficients ranging between 0.338 and 0.642. Thus, the final childhood neglect scale consisted of 39 valid items.

Both the Childhood Trauma Questionnaire-Short Form (CTQ-SF) and the Neglect Scale were originally developed in English and were translated into Indonesian by the researcher prior to data collection. The translated versions were subsequently reviewed by the research supervisor to ensure linguistic clarity, readability, and consistency with the conceptual meaning of the original instruments. Minor wording modifications were made where necessary to improve comprehensibility for Indonesian participants. However, neither instrument underwent a formal cross-cultural adaptation and psychometric validation process in the Indonesian context. Therefore, the findings should be interpreted with consideration of potential cultural and linguistic limitations associated with the use of translated measures.

Reliability Analysis

Reliability analysis was conducted using Cronbach's Alpha to evaluate internal consistency. Reliability reflects the degree to which an instrument produces stable and consistent results (Ghozali, 2021). According to Forester et al., (2024), Cronbach Alpha values above 0.70 indicate

acceptable reliability, while values above 0.80 indicate strong reliability.

The Childhood Trauma Questionnaire–Short Form (CTQ-SF) has demonstrated strong psychometric properties in previous studies, with Cronbach's Alpha coefficients ranging from 0.81 to 0.95 across its subscales and test-retest reliability coefficients of approximately 0.80 (Bernstein et al., 2003). Similarly, the childhood neglect scale adapted from Harrington et al. (2002) demonstrated excellent reliability, with an overall Cronbach's Alpha coefficient of 0.96 and subscale reliabilities ranging from 0.78 to 0.85.

The reliability analysis results showed that: The Body Dysmorphic Symptoms scale obtained a Cronbach Alpha coefficient of 0.878, indicating very good internal consistency. The childhood trauma scale obtained a Cronbach Alpha of 0.854, indicating good reliability. The childhood neglect scale obtained a Cronbach Alpha of 0.944, indicating excellent reliability. These findings indicate that all instruments demonstrated adequate reliability and were suitable for hypothesis testing.

Statistical Assumptions

Prior to hypothesis testing, statistical assumption tests were conducted to ensure the appropriateness of regression analysis. Normality was examined using the Kolmogorov–Smirnov test, while linearity was assessed through linearity tests between predictor and outcome variables. The results indicated that the data met the linearity assumption, although some variables showed deviations from normality. Therefore, additional non-parametric analysis was conducted to ensure the robustness of the findings (Field, 2024; Pallant, 2020).

Statistical Analysis

Data analysis was conducted using IBM SPSS (version 26.0) statistical software. Descriptive statistics were first calculated to summarize sample characteristics and the distribution of study variables, including means, standard deviations, minimum scores, and maximum scores. To facilitate interpretation of participants' scores, descriptive categorization was also performed for body dysmorphic symptoms, childhood trauma, and childhood neglect.

The categorization procedure followed the hypothetical mean and hypothetical standard deviation approach proposed by (Azwar, 2018). Scores were classified into five categories: very low, low, moderate, high, and very high. The classification criteria were determined using the following formulas:

Table 1. Formulas Standar Deviation

Very High	$X > M + 1.5SD$
High	$M + 0.5SD < X \leq M + 1.5SD$
Moderate	$M - 0.5SD < X \leq M + 0.5SD$
Low	$M - 1.5SD < X \leq M - 0.5SD$
Very Low	$X \leq M - 1.5SD$

Notes. X = participant's score, M = mean, SD = standar deviation

Major hypothesis testing was conducted using multiple linear regression analysis to examine the predictive role of childhoodtrauma and childhood neglect on body dysmorphic symptoms. Multiple regression analysis is widely recommended for examining predictive

relationships among multiple independent variables and a dependent variable (Field, 2024).

Minor hypotheses were tested using Spearman correlation analysis due to violations of normality assumptions. Spearman correlation is recommended when data distributions do not meet parametric assumptions (Pallant, 2020). Statistical significance was determined using an alpha level of 0.05.

RESULT

Descriptive statistics were calculated to summarize the central tendency and dispersion of the study variables. The results showed that Body Dysmorphic Symptoms had a mean score of $M = 90.31$ ($SD = 10.48$). Childhood trauma showed a mean of $M = 90.32$ ($SD = 12.14$), while childhood neglect showed a higher mean score of $M = 117.41$ ($SD = 19.71$).

Table 2. Dscriptive Statistic

	Descriptive Statistics		
	Mean	Std. Deviation	N
Body Dys	90,31	10,476	202
Trauma	90,32	12,141	202
Neglect	117,41	19,712	202

Categorization analysis indicated that most participants reported moderate to high levels of Body Dysmorphic Symptoms, with 38.61% in the moderate category and 38.12% in the high category. Similar patterns were observed for childhood trauma and childhood neglect. These categorizations were based on a statistical (non-clinical) classification using hypothetical mean and standard deviation and should not be interpreted as clinical diagnosis or severity of Body Dysmorphic Disorder. These findings indicate that elevated scores were frequently observed in this sample. These categorizations were derived from a statistical classification based on hypothetical mean and standard deviation (Azwar, 2018) and do not represent clinical cut-off scores. Therefore, these categories should not be interpreted as indicating clinical levels or diagnosis of Body Dysmorphic. Overall, these findings indicate that elevated scores on the study variables were frequently observed within this sample.

Assumption Testing

Prior to hypothesis testing, statistical assumptions were evaluated. Kolmogorov–Smirnov tests indicated that body dysmorphic symptoms($KS = 0.190$, $p < .001$), childhoodtrauma ($KS = 0.100$, $p < .001$), and childhood neglect ($KS = 0.135$, $p < .001$) deviated from normality. However, linearity assumptions were satisfied for the relationships between childhood trauma and body dysmorphic symptoms($F = 1.198$, $p < .204$) and between childhood neglect and body dysmorphic($F = 1.029$, $p < .438$). Therefore, regression analysis was considered appropriate, supported by non-parametric correlation analysis.

Hypothesis Testing

Multiple linear regression analysis was conducted to examine whether childhood trauma and childhood neglect jointly predicted body dysmorphic symptoms. The overall

regression model was statistically significant, $F(2,199) = 26.70$, $p < 0.001$, indicating that the predictors collectively explained a significant proportion of variance in Body Dysmorphic. The model produced a multiple correlation

coefficient of $R = 0.460$ and a coefficient of determination of $R^2 = 0.212$, indicating that childhood trauma variables explained 21.2% of the variance in body dysmorphic symptoms.

Table 3. Major Hypothesis Test Result

Model	R	Model Summary		
		R Square	Adjusted R Square	Std. Error of the Estimate
1	,460a	,212	,204	9,348

a. Predictors: (Constant), Neglect, Trauma

Table 4. Multiple Regression Test Result

Model	Sum of Squares	ANOVA			
		df	Mean Square	F	Sig.
1	4666,504	2	2333,252	26,700	,000b
	17390,466	199	87,389		
	22056,970	201			

a. Dependent Variable: Body Dys

b. Predictors: (Constant), Neglect, Trauma

Table 6. Spearman Correlation Among Study Variables

		Correlations			
		Trauma	Pengabaian	Body Dys	
Spearman's rho	Trauma	Correlation Coefficient	1,000	,075	,185**
		Sig. (2-tailed)	.	,286	,008
		N	202	202	202
	Neglect	Correlation Coefficient	,075	1,000	,379**
		Sig. (2-tailed)	,286	.	,000
		N	202	202	202
	Body Dys	Correlation Coefficient	,185**	,379**	1,000
		Sig. (2-tailed)	,008	,000	.
		N	202	202	202

** . Correlation is significant at the 0.01 level (2-tailed).

Results indicated a significant positive relationship between childhood trauma and body dysmorphic symptoms ($r_s = 0.185$, $p = 0.008$). Although the effect size can be considered small according to conventional psychological benchmarks, the relationship indicates that individuals reporting higher trauma exposure tend to report higher body dysmorphic tendencies.

Childhood neglect demonstrated a stronger positive relationship with Body Dysmorphic ($r_s = 0.379$, $p < 0.001$), indicating a moderate association. This suggests that neglect experiences may represent a stronger developmental vulnerability factor for body image disturbance compared to trauma exposure alone.

DISCUSSION

The results indicated that childhood trauma and child neglect jointly showed a significant association with body dysmorphic symptoms, supporting the major hypothesis. The regression model showed a moderate effect size ($R = .460$, $R^2 = .212$, $p < .001$), indicating that childhood trauma and child neglect explained 21.2% of the variance in body dysmorphic symptoms. Because the present study utilized the total CTQ-SF score, the findings should be interpreted as reflecting the cumulative influence of childhood traumatic experiences rather than the specific effects of

any single maltreatment subtype. It is important to distinguish between the regression and correlation findings. The simultaneous regression model indicates the combined association of childhood trauma and childhood neglect with body dysmorphic symptoms. In contrast, the correlation analyses describe the separate bivariate associations between each variable and body dysmorphic symptoms. Therefore, the correlation coefficients should not be interpreted as evidence of the unique contribution of each predictor after controlling for the other variable.

These findings suggest that although childhood trauma represents an important risk factor, body dysmorphic symptoms is a multifactorial disorder influenced by multiple psychological, biological, and social determinants. This finding is consistent with previous literature suggesting that body dysmorphic symptoms is influenced not only by developmental adversity but also by cognitive distortions, neurobiological vulnerability, perfectionism, low self-esteem, and sociocultural appearance pressures (Phillips, 2009). Similarly, Veale (2004) emphasized that body dysmorphic symptoms is maintained by maladaptive cognitive processes such as selective attention to perceived physical flaws, overestimation of appearance defects, and dysfunctional beliefs about physical attractiveness. These findings support the view that early adverse experiences may contribute to vulnerability, while cognitive processes maintain symptom persistence.

The present findings are also consistent with Didie et al. (2006), who found higher rates of childhood maltreatment among individuals with body dysmorphic symptoms compared to controls. Similar conclusions were reported by Malcolm et al. (2021), who identified childhood maltreatment as a significant developmental risk factor for severe body image disturbances in BDD populations. From a trauma theory perspective, these findings may be explained by the long-term psychological impact of early adverse experiences. Herman (2015) suggested that childhood trauma may lead to chronic shame, self-blame, and negative self-schemas that persist into adulthood. These internalized negative beliefs may later manifest as dissatisfaction with physical appearance, particularly when individuals displace psychological distress onto bodily concerns. Consistent with cognitive behavioral models of body dysmorphic symptoms (Neziroglu et al., 2008), early negative interpersonal experiences may contribute to dysfunctional assumptions, such as beliefs that personal worth depends on physical attractiveness. Such beliefs may increase vulnerability to maladaptive body image evaluation and compulsive appearance monitoring.

The results showed that childhood trauma was positively associated with body dysmorphic symptoms, although the magnitude of the relationship was relatively small ($r = .185$, $p = .008$). This finding suggests that childhood trauma may contribute to vulnerability for body dysmorphic symptoms, but it should not be interpreted as a primary or dominant predictor. Because childhood trauma was assessed using the total CTQ-SF score, the present findings reflect the cumulative impact of multiple forms of childhood maltreatment rather than the unique effect of childhood sexual abuse. The modest effect size indicates that the relationship is likely influenced by additional psychological mechanisms that were not directly assessed in the present study.

Previous literature suggests that the psychological consequences of childhood trauma may influence body image through several mediating processes. Experiences of sexual abuse have been associated with increased body shame, self-objectification, post-traumatic stress symptoms, emotion dysregulation, and reduced self-esteem, all of which have been linked to body image disturbances (McElvaney et al., 2022). From the perspective of Objectification Theory, sexual trauma may encourage individuals to adopt an observer's perspective toward their bodies, leading to increased body surveillance and self-criticism. Similarly, traumatic sexualization may contribute to perceptions of the body as damaged, vulnerable, or inadequate, thereby increasing appearance-related concerns. Consequently, childhood sexual abuse may influence body dysmorphic symptoms indirectly through these psychological pathways rather than exerting a strong direct effect (Hayes et al., 2022). Furthermore, resilience, coping resources, and social support may buffer the long-term psychological impact of childhood trauma. (Bonanno, 2004) argued that many trauma survivors demonstrate adaptive functioning despite exposure to significant adversity. Therefore, future studies should investigate potential mediating and moderating variables that may explain the relatively weak association between childhood trauma and body dysmorphic symptoms observed in the present study.

In contrast, childhood neglect demonstrated a substantially stronger association with body dysmorphic symptoms ($r_s = .379$, $p < .001$), suggesting that chronic experiences of emotional deprivation may have more pervasive developmental consequences than discrete

traumatic events. This finding represents one of the most important contributions of the present study and supports previous research indicating that neglect plays a significant role in the development of negative self-concept and body image psychopathology (Malcolm et al., 2021). The finding that childhood neglect was more strongly associated with body dysmorphic symptoms than childhood trauma among gay men may be explained by the chronic and pervasive nature of neglect. Among the two predictors, childhood neglect emerged as the most robust correlate of body dysmorphic symptoms and represents the central finding of this study. Unlike some forms of childhood trauma that may occur as more discrete adverse events, neglect involves a prolonged absence of emotional support, validation, and responsive caregiving throughout critical developmental periods (Silva et al., 2024). This persistent deprivation can disrupt the development of self-esteem, self-concept, and body image, leading individuals to become more dependent on external validation, including evaluations of physical appearance (Mikulincer & Shaver, 2010). Among gay men, who frequently encounter appearance-related pressures and minority stress, these vulnerabilities may increase the risk of developing excessive concerns about perceived physical flaws (Meyer, 2003; Soulliard et al., 2024).

This finding is consistent with previous studies indicating that childhood neglect is closely linked to body image disturbances and body dysmorphic symptoms. For example, Didie et al. (2006) found that individuals with body dysmorphic symptoms reported high rates of childhood neglect and adverse family experiences, suggesting that disruptions in emotional caregiving may contribute to the development of appearance-related psychopathology. Similarly, (Simon et al., 2024) reported that emotional neglect was significantly associated with greater body image impairment and psychological distress among individuals with body image disorders. Therefore, childhood neglect may exert a particularly strong influence on self-worth and body image processes that are central to body dysmorphic symptoms. Mikulincer & Shaver (2010) found that insecure attachment is associated with negative self-image and psychological vulnerability, including body image disturbances. Similarly, schema theory suggests that childhood neglect may lead to maladaptive schemas such as defectiveness and emotional deprivation schemas, which may increase sensitivity to perceived physical flaws (Young, 1999). The stronger association observed for neglect may also be explained by its chronic and pervasive nature.

Descriptive findings further showed that most participants fell within moderate to high body dysmorphic categories, suggesting that body image concerns may be relatively common within this population. This finding aligns with (Oshana et al., 2020), who found higher levels of body dissatisfaction among gay men compared to heterosexual men. Sociocultural explanations may also be relevant. Kimmel & Mahalik (2005) suggested that physical appearance often plays a central role in identity formation within some gay communities, increasing pressure to conform to idealized body standards. Additionally, Minority Stress Theory suggests that sexual minority individuals may experience additional stressors such as stigma, discrimination, and social rejection, which may increase psychological vulnerability. These stressors may increase social comparison processes and internalized stigma, which may further contribute to negative body evaluation (Meyer, 2003). This suggests that body dysmorphic symptoms among gay men may reflect an

interaction between developmental trauma and ongoing social stressors.

In the Indonesian context, gay men may experience additional challenges related to heteronormative social expectations, stigma toward sexual minority identities, concerns about social rejection, and limited opportunities for affirmative social support. Although these contextual factors were not directly measured in the present study, they may intensify appearance-related social comparison and the need for external validation (Parmenas & Partasari, 2025). Thus, the association between childhood neglect and body dysmorphic symptoms may need to be understood within the broader context of developmental adversity and ongoing minority-related stress.

Methodologically, the use of non-parametric analysis due to non-normal data distribution was appropriate. Spearman correlation is recommended when normality assumptions are violated (Field, 2024), supporting the robustness of the analytical approach. Furthermore, the explained variance of 21.2% may be considered meaningful within psychological research, where behavioral outcomes are typically multiply determined (Funder & Ozer, 2019). Practically, these findings highlight the importance of trauma-informed approaches in the treatment of body image disturbances. Interventions such as trauma-focused therapy, cognitive behavioral therapy, and self-acceptance interventions may be particularly relevant for addressing underlying psychological vulnerabilities. Theoretically, these findings support the view that body image pathology is influenced not only by appearance concerns but also by early relational experiences. Therefore, clinical interventions targeting body dysmorphic symptoms may benefit from addressing developmental trauma alongside cognitive symptoms.

Future research should consider longitudinal designs to better understand causal mechanisms, include mediating variables such as self-esteem or resilience, and examine sociocultural moderators such as minority stress. Expanding research to more diverse sexual minority populations may also improve generalizability.

CONCLUSION

This study demonstrates that childhood trauma and childhood neglect are associated with body dysmorphic symptoms among gay men. The findings highlight the importance of trauma-informed perspectives in understanding body image disturbances and suggest that childhood neglect shows a stronger association with body dysmorphic symptoms compared to childhood trauma due to its impact on self-concept formation and emotional security. Specifically, childhood neglect demonstrated a stronger association with body dysmorphic symptoms than childhood trauma.

These results support developmental psychopathology frameworks indicating that early adverse experiences contribute to maladaptive self-schemas that may later manifest as appearance-related distress. Furthermore, the findings suggest that body dysmorphic symptoms should be understood within an integrative biopsychosocial framework in which developmental experiences interact with cognitive vulnerabilities and minority stress processes. From a clinical perspective, these results underscore the importance of trauma-informed and cognitively oriented interventions that address both developmental adversity and maladaptive appearance beliefs. It should be noted that these findings reflect self-

reported body dysmorphic symptoms rather than clinical diagnosis of Body Dysmorphic Disorder. Overall, this study contributes to trauma-based understandings of body image disturbances and emphasizes the importance of integrating developmental experiences into psychological conceptualizations of body image concerns.

Limitations

This study has several limitations. The cross-sectional design does not allow causal inferences regarding the associations between childhood trauma, childhood neglect, and body dysmorphic symptoms. Participants were recruited through an anonymous online survey distributed via social media platforms; therefore, the sample may be subject to self-selection bias, as individuals who chose to participate may differ from those who did not participate. The CTQ-SF and Neglect Scale were originally developed in English and translated into Indonesian by the researcher, with the translations reviewed by the research supervisor for clarity and conceptual consistency. However, neither instrument underwent a formal cross-cultural adaptation or psychometric validation process in Indonesia. Therefore, the cultural equivalence of these measures cannot be fully assured. In addition, the study used the total CTQ-SF score rather than individual subscales; thus, the findings should be interpreted as reflecting cumulative childhood trauma rather than the effects of specific maltreatment subtypes.

All variables were measured using self-report questionnaires, which may have introduced response bias, including social desirability bias. Reports of childhood trauma may also be affected by recall bias. Furthermore, minority stress, self-esteem, body-related shame, self-objectification, and post-traumatic stress symptoms were not measured. These factors may help explain the associations observed in this study and should be examined in future research. This study did not use clinical diagnostic interviews; therefore, the findings reflect self-reported body dysmorphic symptoms rather than clinically diagnosed Body Dysmorphic Disorder (BDD). Moreover, the body dysmorphic symptoms scale developed by the researchers requires further psychometric evaluation, including formal content validation and factor analysis.

Formal ethical approval was not obtained prior to data collection, representing an important methodological limitation. Nevertheless, participants were informed about the sensitive nature of the study, participation was voluntary and anonymous, and contact information for a professional psychologist was provided in case participants experienced distress or retraumatization related to uncomfortable past experiences. Future studies are encouraged to obtain ethical approval, employ formally validated and culturally adapted instruments, include clinical diagnostic procedures where appropriate, and use more rigorous methodological designs.

DECLARATION

Ethics approval and consent to participate

This study was conducted in accordance with ethical standards for research involving human participants. Data were collected through an anonymous online survey without collecting any personally identifiable information. Participants were informed about the purpose of the study and that their participation was voluntary. Consent to participate was implied through the completion of the questionnaire.

Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

Conflicts of interest statement

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

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Artificial Intelligence-Assisted Technology

During the preparation of this manuscript, the authors used generative AI to assist in language refinement, grammar correction, and improving the overall readability of the text. The use of AI was limited to linguistic assistance and did not involve the generation of scientific ideas, data analysis, results interpretation, or conclusions. All research processes, including study design, data collection, analysis, and interpretation, were conducted solely by the authors.

Authors' contributions

The first author (Ismawati): Ismawati conceptualized the study and determined the research design, methodology, and procedures. She conducted data collection, performed statistical analyses, and prepared the results and research outputs.

Second author (R. D. Astuti): R. D. Astuti contributed to the development of the research design, methodology, and procedures, supervised the research implementation, assisted in the data analysis process, and monitored the achievement of research outcomes.

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