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Body Dysmorphic Disorder, Trauma, Shame, and Person-Centred Therapy

Body Dysmorphic Disorder

Body Dysmorphic Disorder (BDD) is classified in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) under the category of Obsessive-Compulsive and Related Disorders. It is characterized by intrusive preoccupations with perceived physical flaws that are typically unnoticeable to others, leading to repetitive behaviours such as excessive grooming, mirror-checking, or seeking reassurance (APA, 2013).

The NHS (2023) defines BDD as a mental health condition where individuals spend excessive time fixating on perceived imperfections in their appearance, often imagining flaws that others do not see. BDD affects people of all genders and can occur at any age but is most common among teenagers and young adults.

Contrary to misconceptions, BDD is not rooted in vanity or self-absorption. It is a distressing and debilitating condition that significantly disrupts daily life and emotional well-being (NHS, 2023). Veale et al. (2016) estimate that approximately 2% of young people experience BDD, a prevalence supported by other research, including Buhlmann et al. (2010).

The condition's impact is profound. Angelakis et al. (2016) report that 80% of young people with BDD experience suicidal thoughts, with 40% attempting suicide. Jassi and Krebs (2021) highlight these alarming statistics, emphasizing that BDD ranks among the

most severe and high-risk mental health disorders. Despite this, it remains underdiagnosed and often overlooked, leaving many individuals without adequate support or treatment.

This highlights the urgent need for greater awareness and more accessible interventions to address the life-threatening challenges faced by those living with BDD.

Veale & Bewley, (2015) explain that individuals with Body Dysmorphic Disorder may seek help from general practitioners, dermatologists, cosmetic and ENT surgeons, maxillofacial specialists, orthodontists, gynaecologists, or urologists, aiming to address their perceived physical flaws. Despite being a severe psychiatric condition, BDD less frequently comes to the attention of mental health services and usually only when complications such as depression, social isolation, or suicide risk are present.

However, Rautio et al., (2020) point out that young people might struggle to access medical services due to age restrictions and cost, but approximately 50% of participants stated that they would like cosmetic treatments. Jassi & Krebs (2021), report that some parents have supported their children to have plastic surgery, thinking that this would put an end to their child's suffering. However, research has demonstrated that such procedures leave people with BDD with a feeling of deep dissatisfaction with the outcome and a desire for further treatment (Rautio et al., 2020).

Jassi & Krebs (2021) explain another reason BDD is often overlooked in mental health care is that individuals with the disorder tend to hide their body image concerns due to feelings of shame or embarrassment. They attempt to conceal areas of their body they

are unhappy with, using strategies such as applying makeup, wearing specific clothing, using hats, adjusting their hair, wearing sunglasses, or altering their posture. Some avoid activities that require them to stop these behaviours, such as removing a hat for a formal event. This camouflaging often becomes repetitive and ritualistic, sometimes resembling compulsive behaviours, like reapplying makeup dozens of times a day (Steketee & Steketee, 2011)

As a result, even when people suffering with BDD seek mental health support, BDD symptoms are frequently unrecognised and misdiagnosed as conditions like depression or social anxiety. Research, such as a survey by Schulte et al. (2020), reveals that only 15% of those with BDD receive an accurate diagnosis.

Aetiology

According to the Oxford Handbook of Obsessive Compulsive and Spectrum Disorders (2012) the aetiology of BDD remains elusive, but it is likely that biological, psychological, and socio-environmental factors play a role in the development and maintenance.

The diathesis-stress model of Body Dysmorphic Disorder (BDD) suggests that the condition arises from a combination of biological predispositions and environmental stressors. Twin studies have shown that genetic factors contribute to about 42%–44% of the variability in symptoms resembling BDD, while the remaining variability is attributed to unique environmental factors not shared between individuals (Bowyer et al., 2016).

Schneider et al. (2020), emphasise that adverse experiences during childhood can significantly harm a child's self-perception during critical developmental stages. These negative experiences often result in long-lasting consequences, affecting both mental and physical health well into adulthood, alongside the challenges they create during childhood itself (Schneider et al., 2020).

Trauma as Aetiological Factor

Constantian (2019), explores the psychological connection between early life trauma and body dissatisfaction. His research highlights how experiences of childhood abuse can lead to profound body shame, with individuals often perceiving their bodies as flawed or unacceptable. This internalised shame can drive some individuals to pursue cosmetic surgery compulsively in an attempt to "fix" their appearance and alleviate emotional distress.

Constantian (2019), further emphasises the role of trauma in shaping self-image and links childhood abuse with a heightened likelihood of body dysmorphic disorder (BDD) and related behaviours. He discusses how addictive plastic surgery is often less about aesthetics and more about attempting to manage unresolved trauma and feelings of worthlessness. The author advocates for trauma-informed therapeutic interventions to address the root causes of body shame.

This growing evidence underscores the importance of addressing trauma histories in therapeutic interventions for BDD. By focusing on the psychological and emotional roots

of the disorder, clinicians can better tailor treatments to mitigate the impact of trauma and improve outcomes. A study by Didier (2016) has demonstrated that adults with BDD report elevated levels of childhood maltreatment, with up to 79% of patients reporting abuse.

Craythorne et al. (2022) utilised Interpretative Phenomenological Analysis (IPA) to explore and interpret the experiences of individuals living with BDD. The study aimed to uncover participants' beliefs about the origins of BDD and examine how they navigate life with a distorted perception of self. The study identified several potential factors contributing to the development of BDD, including experiences of childhood bullying, criticism, rejection, and abuse.

The process of reintegration or treatment

The challenge of trauma treatment is not only dealing with the past but, even more, enhancing the quality of day-to-day experience (Van der Kolk, 2017, p.85).

The NHS (2023) recommends either Cognitive Behavioural Therapy (CBT) or medication in form of Selective Serotonin Reuptake Inhibitors (SSRIs). For more severe symptoms, the service recommends a combination of both. However, they also point out that it can be difficult to access talking therapy.

Post–Traumatic Stress from the person-centred perspective

Joseph (2017) explains that most literature on post-traumatic stress disorder does not mention person-centred theory. Person-centred theories do not assume that specific conditions require certain treatment and do not adopt the psychopathology of the medical model. However, in recent years work has been conducted to provide a person-centred understanding of PTSD. Joseph (2017), further explains that despite Rogers writing long before the term PTSD has been coined, he found another way of talking about its symptoms, he described it as the breakdown and disorganisation of the self-structure. Rogers (1959), explains this as a process that occurs when there is a significant discrepancy between an individual's self-concept and their lived experiences. This incongruence causes the individual's self-structure (their sense of identity and values) to lose stability, leading to psychological distress. However, the defining features of PTSD are the phenomena of re-experiencing traumatic events and efforts to avoid reminders of the trauma and Rogers (1959) has explained this too. The disorganization that arises when the self-structure collapses involve a conflict within the individual. On one side, they strive to bring their experiences into conscious awareness (intrusion). On the other, they resist these experiences, clinging to their established self-concept (avoidance), creating a tension between growth and the desire for stability.

Polyvagal Theory and Trauma

Polyvagal Theory, developed by Dr. Stephen Porges, offers a framework for understanding how the autonomic nervous system (ANS) responds to trauma. It

emphasizes the role of the Vagus nerve in regulating physiological states and explains how these states influence emotional and social behaviour. The Theory identifies three primary states of the ANS that impact how individuals respond to stress and trauma.

Social Engagement System (Ventral Vagal Pathway): This state is associated with safety and connection. It enables calmness, emotional regulation, and healthy social interaction.

Sympathetic Activation (Fight or Flight): When a threat is perceived, the ANS shifts to a state of arousal, enabling the individual to respond with fight or flight behaviours.

Dorsal Vagal Shutdown (Freeze or Collapse): In situations of overwhelming threat, the body may enter a shutdown state, characterized by numbness, disconnection, and reduced energy.

Van der Kolk (2014) explains that trauma disrupts the ability to transition smoothly between these states. Survivors often become stuck in fight-or-flight (hyperarousal) or freeze (hyperarousal) responses, leading to symptoms such as hypervigilance, emotional numbness, and difficulty forming relationships.

In practice, therapists may use techniques such as grounding exercises, breathing techniques, and mindfulness to help clients become more aware of their physiological responses. This can lead to a greater sense of control over emotions and an improved ability to self-regulate. By encouraging clients to reconnect with their body sensations and fostering a sense of safety in the therapeutic environment, polyvagal therapy aims to reduce the impact of trauma-related dysregulation.

Research has shown that polyvagal-informed interventions can be effective for trauma, attachment issues, and chronic stress. For example, studies have found improvements in

emotional regulation and a reduction in trauma symptoms when clients engage in practices that activate the ventral vagal system (Porges, 2011).

Overall, polyvagal therapy is a powerful approach to healing trauma by addressing the physiological foundations of emotional and behavioural responses, providing clients with the tools to regulate their nervous system and find a greater sense of calm and connection in their lives.

Attachment Theory

Stovall –McClough and Dozier (2016) concluded that adult psychiatric disorders are almost always associated with non-secure attachment patterns or as they call it “attachment states of mind”.

Bolby’s (1953) attachment theory explains that the first year of life is to form an attachment relationship. Infants are unable to regulate their own distress and need their attachment figure to help them manage their arousal to return to baseline. The process of co-regulation will over time teach the child the ability to deal with emotional distress in later life. Tronick (2007) explains that perfect attunement is impossible and that the best functioning mother infant pairs were only in an attuned state for 30 per cent of the time. This cycle of rupture and repair allows the infant to learn to tolerate mis-attunement and to develop resilience to later life stressor.

McCrory and Viding (2015) propose the theory of latent vulnerability, which highlights how early life experiences shape an individual's future interactions with the world. Adverse

experiences, such as insecure or disorganised attachment, can negatively impact a child's biology and behaviour. These changes reduce the likelihood of forming robust social connections and increase the tendency to focus on negative memories. Such alterations influence how a child perceives and engages with their environment, potentially leading to adaptive or maladaptive strategies depending on the context. This framework suggests that mental health outcomes related to early adversity emerge gradually through intricate interactions between the caregiving environment and the child's adaptations, aligning with Bowlby's concept of "branching railway lines" of development. Attachment sets the direction, but life provides junctions at which things can get considerable worse or considerable better (Bowlby 1973).

According to Bowyer et al. (2016), attachment plays a significant role in emotional development. A secure attachment fosters a stable self-concept and effective emotional regulation, making individuals less likely to develop body image concerns. Insecure (anxious or avoidant) attachment patterns can lead to heightened self-criticism, dependence on external validation, and a distorted sense of self-worth factors often seen in BDD. Disorganised attachment, often resulting from trauma or inconsistent caregiving, may exacerbate feelings of shame and confusion about self-identity, contributing to the obsessive focus on physical appearance in BDD.

Attachment theory provides a valuable framework for understanding BDD, particularly its origins in relational and emotional dynamics during early life. BDD, characterised by an intense preoccupation with perceived physical flaws, can be influenced by attachment patterns that shape an individual's self-image and emotional regulation.

Bonev and Matinova (2021) suggest that body image develops as part of our attachment relationships, which are built on feelings of safety and protection. When these relationships are disrupted or disorganised, they fail to provide the security needed for healthy development. Body image is shaped through processes like caregivers reflecting the child's needs, responding sensitively to signals, and maintaining synchrony in interactions.

In early life, a baby's attachment needs are closely tied to physical care, with the primary caregiver's responses playing a key role in meeting these bodily needs. When attachment is disorganized or traumatic, it can leave lasting effects, often expressed through struggles with body image. Trauma is seen as a form of loss, and unprocessed grief or unresolved pain can manifest in physical ways, making the body a focal point for understanding these issues (Bonev and Matinova, 2021).

Shame

Shame is a crucial emotion to understand in therapeutic practice, both from the client's perspective and the therapists. It can often operate outside conscious awareness or linger at the periphery of awareness, manifesting in various subtle or overt ways. *Shame literally makes a person shrink: the eyes drop, the head hangs, the chest collapses, the shoulders curve forward*" (Kepner, 2003, p. 36).

Joyce and Sills (2018) explain about the origins of shame. How the developing child needs to learn to conform to societal rules in order to be accepted as part of the community. It is very important to note that this “healthy shame” is only short lived.

Joyce and Sills (2018) further expand that for some clients, shame is so deeply ingrained that it frequently surfaces within the therapeutic relationship. Lee and Wheeler (1996) describe this phenomenon as "shame-binds," which are rooted in a person's earliest relationships. When a young child expressed needs or emotions with energy or excitement, caregivers might have responded dismissively, scornfully, or even aggressively, without offering connection, understanding, or forgiveness. These repeated negative responses led the child to internalize beliefs such as "my crying makes people angry," "my excitement is too much," "my anger causes abandonment," or simply "I am too much." Over time, these aspects of self-expression became associated with a core expectation of disapproval. Consequently, the feeling of shame became inextricably linked to the original unmet need or emotion.

Kaufman (1989) coined the term “internalised shame”. In some toxic families or cultures, regulatory mechanisms become so pervasive that individuals may develop an almost constant feeling of shame about their natural impulses. This leads the person to have an automated shame reaction to the slightest stirring of his own desire or relational needs.

Stechler and Henton (2022) empirical study about shame, trauma, and dissociation among women with BDD in physical intimate relationships, found that participants were often unaware of how their partners saw them. Instead, the way they perceived their

partners' thoughts reflected their own self-image. This could suggest an unconscious process where participants projected their own thoughts and feelings onto their partners, blurring the distinction between their own and their partners' minds. This fusion made it hard for them to believe their partners genuinely liked or wanted to be with them. These dynamics reinforced feelings of low self-esteem and worthlessness.

Stechler and Henton (2022) argue that being observed by others can evoke feelings of shame, particularly in individuals with Body Dysmorphic Disorder (BDD). For those with BDD, being looked at triggers shame about their appearance and creates a need to perform or adopt a role to mask their perceived flaws. Hiding the body becomes a way to conceal what they believe is a defective true self. Under the gaze of others, the natural, spontaneous experience of being in their body is disrupted, leaving the person with BDD feeling overwhelmed and reduced to an object of attention. For some participants, this led to fears of rejection and sadness at the thought of losing their partners. Others struggled to accept compliments about their appearance, sometimes treating them as a joke. One participant even expressed suspicion, questioning why their partner stayed or who influenced their decision. Their findings further suggest to build client's ability to self-soothe and to reduce feelings of shame.

Working with shame (Gestalt therapy)

Joyce and Sills (2018) explain that shame is always a shared experience, and when it appears in therapy, it often signals a rupture in the therapeutic relationship. It may indicate

that the therapist has unintentionally triggered the client's shame or failed to provide adequate relational support. However, after the therapeutic relationship has been re-established, it might be beneficial to find out about the client's earliest experience of shame and identify the beliefs and attitudes that were established at that time. The authors further emphasise the importance of attuning to non-verbal cues of the client as many shame reactions will have been formed when the client was too young to articulate or understand the shaming process. Experiencing shame can be very isolating so the therapist ideally finds a way stand next to the client as a companion rather than an observer. Shame often operates beneath conscious awareness. What might simply be a small relational misunderstanding can feel to the person like total rejection, confirming feelings of worthlessness or being inherently bad. In therapy, a key goal is to help clients recognise that they are experiencing a specific emotion - shame - which is just one aspect of who they are. This process also shows them that shame is a feeling they can acknowledge, tolerate, and even share with others in a supportive relationship. In addition, it is essential to recognise the shame behind other emotions, such as anger and fury. This contrasts with withdrawal and is often directed at the counsellor. A key challenge for the counsellor is managing their own feelings of shame in response to client criticism or anger. It is essential to stay grounded, offering steady support while calmly withstanding the client's emotional intensity without withdrawing or retaliating. Keep responses brief and empathetic, demonstrating resilience in the face of the interaction. Once emotions have settled, the counsellor can work with the client to understand what occurred, acknowledge their own role in the shared dynamic, and explore the co-created experience together.

The experience of shame is often accompanied by a strong desire to withdraw or hide. Helping the client resist this urge and take the risk of connecting with others, by exploring their fears and assumptions, can be deeply healing. However, the level of support offered must be carefully balanced. The client needs to feel that you are empathically present and supportive, but overly protective behaviour can be counterproductive. Treating the client as fragile might reinforce feelings of shame by suggesting they are too vulnerable or that their fears are justified. The goal is to normalise the experience together, framing shame as a manageable emotion that can be confronted and worked through within a trusting therapeutic relationship.

Shame can lead to either a numbness or detachment from bodily awareness, or the opposite extreme, a flood of overwhelming sensations. In response, the body may shut down, collapse defensively, or lose its natural capacity for self-support. To address this, it is helpful to begin by guiding the client to focus on steady breathing, reconnect with physical sensations, and use mindfulness to re-establish a supportive connection with their body. A therapist who maintains a grounded and embodied presence, breathing calmly, can model this process and encourage the client to develop their own sense of bodily self-support.

Transference and Counter-transference

Joyce and Sills (2018) explain that in Gestalt therapy, transference is seen as a projection of past relationships, emotions, or dynamics onto the therapist. They describe it as a relational dance of mutual influencing and its manifest in the present moment. The therapist encourages the client to recognise and explore these projections as part of their

current experience, often using dialogue or experiential techniques. This process helps clients become aware of unresolved issues or patterns from the past that influence their behaviour and emotional responses in the present. A key feature of a healthy relational process is its capacity for continuous updates, where current experiences reshape existing expectations and predictions. However, there are instances where individuals essentially decide, whether consciously or not, that past patterns will always apply, preventing them from updating their frame of reference. This inability to adapt often stems from relational habits deeply embedded in unconscious processing, forming a foundational structure that lies beyond immediate awareness or intentional adjustment (Wheeler, 2000). Joyce and Sills (2018) further explain that we can recognise transference in clients when they might treat us in a strange or inappropriate way, and they are not seeing the therapist at all. Countertransference in Gestalt therapy refers to the therapist's emotional responses to the client, which may reflect their own unresolved issues or reactions to the client's projections. However, Gestalt therapy emphasises the therapist's use of self-awareness to differentiate between their own experiences and what belongs to the client. The authors further conclude that transference is an inevitable part of relationship and hence will become part of the relationship between the client and the therapist. However, the emphasis is on the past that is still active in the present, and its interaction in the relationship with the here and now therapist (Joyce and Sills, 2018).

Conclusion

While Body Dysmorphic Disorder (BDD) has started to gain increased attention from the research community, significant gaps remain, particularly in the realm of person-centred

research. This may be attributed to the principles of person-centred psychotherapy, which traditionally avoids labelling and pathologising clients. Instead of focusing on diagnostic categories, this approach emphasises the client's subjective experience and allows for their concerns and challenges to naturally unfold within the therapeutic process.

At the same time, research consistently highlights the role of childhood trauma and Adverse Childhood Experiences (ACEs) in the development of BDD. These early life experiences appear to influence the disorder's onset and severity. The non-directive nature of person-centred therapy provides space for clients to explore and process these underlying issues organically, without being confined to a predefined framework. This flexibility supports a holistic understanding of the client's experiences, fostering a therapeutic environment where healing can emerge naturally from the client's own pace and readiness.

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