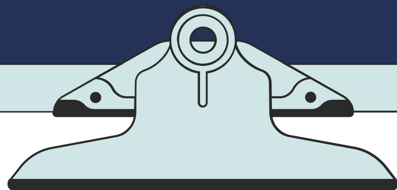
COMPLEX TRAUMA PERSPECTIVES

ISTSS COMPLEX TRAUMA SPECIAL INTEREST GROUP NEWSLETTER



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Get in Touch

Have questions, ideas, or want to get involved with the Complex Trauma SIG? We'd love to hear from you. Reach us anytime at complextrauma.sig@istss.org and a member of our team will be in touch.

UPDATES & ANNOUNCEMENTS

ISTSS Complex Trauma SIG Meetings

Bimonthly on the 3rd Friday of every other month
8am PST / 9am MST / 10 CST / 11am EST

ISTSS 42nd Annual Meeting

Traumatic Stress in a Troubled World: Collaboration on Evidence and Action
September 23-26, 2026
San Antonio Marriott Rivercenter | San Antonio, Texas

For more information:
https://istss.societyconference.com/v2/#card/registration

MEET THE TEAM

Kayleigh Watters, PhD

CO-CHAIR

I am a licensed clinical psychologist in the state of California (PSY 34749). In addition to private practice I am also an assistant professor at Palo Alto University. I teach classes related to statistics, substance use, trauma, and psychopathology. I am also the director of the Trauma, Diversity, and Systemic Change (TDSC) lab. My research focuses on complex trauma, the impact of discrimination on trauma, sexual violence, and reproductive healthcare. She is an applied researcher and uses the outcomes of research to find ways to advocate for changes in different settings.

I am also the co-chair of the Complex Trauma Special Interest Group for the International Society of Traumatic Stress Studies (ISTSS). I am a certified provider of CPT. I received my doctoral degree in clinical psychology with an emphasis in adult trauma from Palo Alto University. I completed my predoctoral internship at Oregon State University and my postdoctoral fellowship at the Stanford Psychiatry and Behavioral Sciences Department. I have also had extensive training in PTSD, complex trauma, grief, anxiety, and depression through the San Francisco VA and StarVista.

Carine Leslie, MS

CO-CHAIR

I am currently an acute care psychology predoctoral resident at Cincinnati Children's Hospital Medical Center. I will receive my PhD in clinical psychology from Virginia Commonwealth University in May 2026. My research focuses on the interplay of socioecological and contextual factors that influence trauma-related outcomes among adolescents exposed to complex trauma and violence.

Clinically, I specialize in treating trauma, depression, chronic suicidality, and self-harm in adolescents. I am also on a comprehensive DBT team. Following my residency, I will stay at Cincinnati Children's Hospital as an acute care psychology fellow to provide care across inpatient psychiatric units and develop evidence-based programs to improve standards of care.

Malachi Gillihan, MS

CO-CHAIR

Malachi Gillihan is a trauma specialist, yogi, and spiritual counselor, integrating his lived experience with Complex-PTSD as a male survivor of sexual trauma with his PhD research in East-West approaches to trauma recovery, healing, and growth.

Malachi has practiced and trained under teachers including Dr. Dan Siegel, Dr. Judith Herman, Judith Lasater, Sean Feit-Oakes, and Deb Dana. Based in Berkeley, CA, he maintains a small private practice primarily supporting clients with histories of CT and sexual trauma, as well as training healing professionals in approaches to trauma recovery.

Brianna Domaceti, MS

STUDENT CO-CHAIR

Brianna Domaceti, MS (she/her) is a Clinical Psychology PsyD candidate at Nova Southeastern University and serves as Student Co-Chair of the International Society for Traumatic Stress Studies (ISTSS). She is currently completing her predoctoral internship at Vantage Point Center for Psychotherapy.

Her clinical and research work focuses on complex trauma and complex PTSD, with particular attention to attachment disruptions and relational patterns that develop in early environments and continue to shape adult identity and relationships. She has trained in private practice, as well as in anxiety-focused and trauma-specialty settings, including the Anxiety Treatment Center (ATC) and the Trauma Resolution and Integration Program (TRIP) ...

... where she provided trauma-informed care to adult survivors of childhood abuse and neglect while also contributing to research and manuscript development.

Brianna has presented her research at conferences including ISTSS, ISSTD, and APA. She remains actively involved in trauma-focused professional organizations and is committed to integrating research, clinical practice, and advocacy to advance trauma-informed, relationally attuned care and to support the development of emerging trauma professionals.

Anastasiya Chevychalova, BS

STUDENT CO-CHAIR

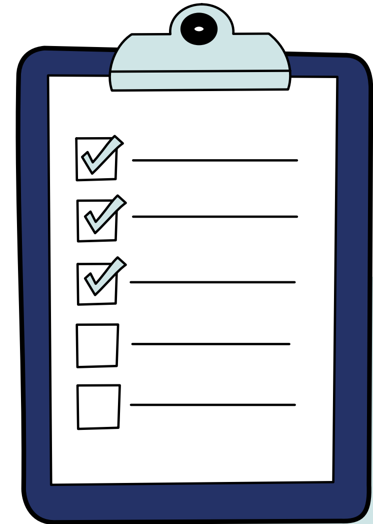
Anastasiya Chevychalova is a Clinical Psychology PhD student at Palo Alto University in California, training within the Trauma Area of Emphasis. She serves as Student Co-Chair of the ISTSS CT-SIG, where she currently leads the development of *Complex Trauma Perspectives*. She also serves as Secretary for the Association of Traumatic Stress Studies (ATSS) at PAU, an organization dedicated to fostering professional development and advancing trauma awareness across the university community. Ana is a practicum student at The Clinics @ PAU, where she provides individual psychotherapy to a diverse adult caseload presenting with trauma-related conditions.

She is also a research member of the Early Intervention Clinic (EIC), which provides and evaluates evidence-based treatments for individuals with PTSD following recent traumatic events. Her research centers on psychological and emotional maltreatment in childhood, with broader interests in how relational trauma disrupts affect regulation, personality development, and interpersonal functioning across the lifespan. Clinically, she is interested in working with CPTSD and suicidality, with long-term goals of integrating trauma-focused treatment and crisis intervention within a phase-based model of care.

CLINICAL CORNER

New Professional Practice Guideline for Adults with Complex Trauma Histories

Christine A. Courtois, PhD, ABPP, Chair
Paul A. Frewen, PhD, Co-Chair



We are pleased to announce the availability of a new *Professional Practice Guideline for Working with Adults with Complex Trauma Histories*, published jointly by the American Psychological Association (APA, Division 56, Trauma Psychology) and the International Society for the Study of Trauma and Dissociation (ISSTD) (APA, 2024). The guideline has been under development for a considerable period of time and involved input from an international panel of identified experts in complex trauma. The guideline document is available in its entirety at https://www.apa.org/practice/guidelines/adults-complex-trauma-histories.pdf

At present, there are two different types of professional practice guidelines, per the American Psychological Association: Clinical Practice Guidelines (CPG), and Professional Practice Guidelines (PPG). CPG are based on a systematic review of the Randomized Control Trial (RCT) treatment efficacy research and evaluation of same by a multidisciplinary panel of experts who make graduated recommendations for treatment strategies based on the strength of the evidence. The APA published its first CPG on the treatment of adults with PTSD in 2017 (APA, 2017) and it is currently under revision.

In contrast, PPG such as the new PPG for Working with Adults with Complex Trauma Histories, review available evidence and incorporate clinical consensus descriptions to establish recommendations for clinicians and others regarding treatment approaches, but do not make treatment specific recommendations. Both types of guidelines can thus be considered complimentary and can be used together. Of note, a PPG for the treatment of adults with PTSD is also in the APA approval pipeline. Once published, it can be usefully co-applied with the current PPG for working with adults with complex trauma histories. Both PPG offer different but compatible information on the treatment of traumatized individuals across the spectrum of severity and impact.

Professional Practice Guideline for Working with Adults with Complex Trauma Histories

Guidelines (cont.)

Complex trauma has received increasing professional and public recognition in the past several decades and new research findings indicate that it is likely to be the most common form of trauma. Quoting from the new PPG for Working with Adults with Complex Trauma Histories:

> While the current PPG may apply to persons with various trauma histories, the guidelines have been articulated explicitly in reference to persons with more "complex" trauma histories...The complex trauma formulation...expands the definition of trauma from merely physical forms to include other ongoing, progressive trauma and entrapping/coercive interpersonal violence, usually over the course of childhood but occurring at any age and having age- and stage-related developmental and posttraumatic impact. Regrettably, the term "complex trauma" has often been misunderstood within the literature, perhaps owing to authors conceptualizing it to imply a categorical distinction from "simpler" forms of trauma as conventionally defined in the literature, which may have invalidated the experiences of some victims. In contrast, the present guidelines employ a dimensional, continuous model in understanding a person's trauma history as increasingly "complex," as a linguistic device, to the degree that they have experienced traumatic life events: (a) repeatedly, (b) in (often significant) interpersonal relationships and (c) under intentional circumstances, (d) that transgressed deeply held moral/ethical principles, and (e) occurred early and across multiple developmental stages. As such, trauma complexity may be best understood on a continuum, from non-interpersonal and accidental (and thereby ethically neutral) circumstances that occurred in a singular instance, to repeated, deliberate, immoral transgressions that occurred within familial, intimate, peer or other close relationships [including in organizations or other systems where they might occur in highly organized forms] from a young age and across the lifespan.

Ford & Courtois (2020) also identified several primary characteristics that differentiate complex trauma from one-time/time-limited and unintentional or impersonal forms of trauma: (1) interpersonal experiences and events that often involve relational betrayal and are perpetrated by trusted others; (2) repetitive, prolonged, pervasive and in some cases, ongoing/never-ending events that are often progressive and escalating in severity; (3) involve direct attack, harm, and/or neglect and abandonment by caregivers or other adults who are responsible for responding to or protecting the victims—this may extend to organizations and cultures that are disbelieving of the victimized individuals and deny the occurrence of the traumatic circumstances and so are unresponsive or that support a safe haven for perpetrators; (4) occurs at developmentally vulnerable times in the victim's life, often beginning in early life [but can also occur late in life with the highly vulnerable elderly]; (5) has great potential to compromise severely a child's physical and psychological maturation and development and to undermine or even reverse important developmental attainments at any point in the lifespan.

Acknowledgement of the effects of additional types of traumatic stressors—including those those that are psychological/emotional as well as physical—and that occurred recently and in the past, has opened greater understanding of the role of revictimization and repeated and layered forms of trauma over the entire lifespan as complex and cumulative trauma. Additionally, collective forms of trauma, many of which are embedded in cultural norms and beliefs that are frequently ancestral/historical/transgenerational in nature, have also been identified as complex.

The diagnosis of Complex Posttraumatic Stress Disorder (CPTSD) was included in the *International Classification of Disorders-11* of the World Health Organzation (2021), as a "sibling diagnosis" to the recognized symptom criteria of PTSD, such as are similarly defined in the *Diagnostic and Statistical Manual-5 TR* (American Psychiatric Association, 2022). CPTSD includes additional criteria defined as Difficulties of Self Organization (DSOs) in emotional regulation, identity, and relationship with others and includes attention to dissociation. In addition to these posttraumatic diagnoses, complex trauma is also recognized as being *transdiagnostic* and, like more conventional forms of trauma, associated with a broad range of psychiatric as well as medical and psychosocial effects. These often compound the treatment and confound treating professionals until they are recognized as posttraumatic by these same professionals using a "trauma lens" in their assessments and determinations.

Guidelines (cont.)

The PPG for Working with Adults with Complex Trauma Histories identifies and discusses the following 7 principles of treatment including their rationale and application, using the acronym HISTORY as a mnemonic: 1) Humanistic, attending to and respecting the uniqueness and value of each individual and their history and context; 2) Integrative, applying a variety of treatment strategies according to the unique goals and needs of the individual; 3) Sequential, attending to issues of personal safety, stabilization, and skill building prior to direct exposure to trauma processing; 4) Timeline, giving attention to the lifespan chronology of the individual's traumatic exposure; 5) Outcomes, establishing and working towards mutually established and defined goals that not only involve symptom reduction but are strength-based and individualized; 6) Relational, providing a trustworthy and responsive relationship, a "safe haven" and "learning laboratory" for the client to develop a more secure self and relationship style; and, 7) whY, reappraising maladaptive meanings and addressing spiritual and existential questions about the trauma and its impact and role in the individual's life. These principles all fall within the scope of Trauma-Informed and Trauma-Responsive Care strategies for professionals and organizations. They also incorporate the guidelines on trauma psychology treatment competencies (APA, 2015).

In the final section of the PPG, several additional issues are addressed. These include the lack of attention to trauma in the training curricula of most service professions, including psychology, and the need for specialized training and consultation/supervision to supplement generic clinical training when providing care to complexly traumatized individuals. As treatment strategies are under constant development, clinicians are further encouraged to keep abreast of current research and treatment literature and to engage in continuing education efforts. Attention to the provider's overall emotional well-being is also recommended due to the strain and intensity that can accompany working with a highly traumatized population. Clinicians and others should be knowledgeable about vicarious traumatization and treatment traps that are common occurrences when working with adults with complex trauma histories. Such awareness and self-care strategies work against burnout and support sustainability and satisfaction in doing this work. Of necessity, issues of diversity, equity, and inclusion are to be centered in this treatment as the individual's contextual issues and intersectionality can impact the motivation for and occurrence of traumatization, its understanding by the victim and its impact (including culture-bound idioms of distress and taboos), and the need for specialized considerations in the treatment.

Finally, the parallel development of posttraumatic growth in the therapist and the client has been identified. The client's resolution of traumatic impact and their personal recovery and life restoration can result in a high degree of professional satisfaction and pride for the clinician working with this population.

We hope that psychologists and other mental health professionals will aspire to be guided by the Humanistic, Integrative, Sequential, Temporal, Outcomes-focused, Relational, and Causal (Why?) principles underline by this new PPG in their work with adults with complex trauma histories.

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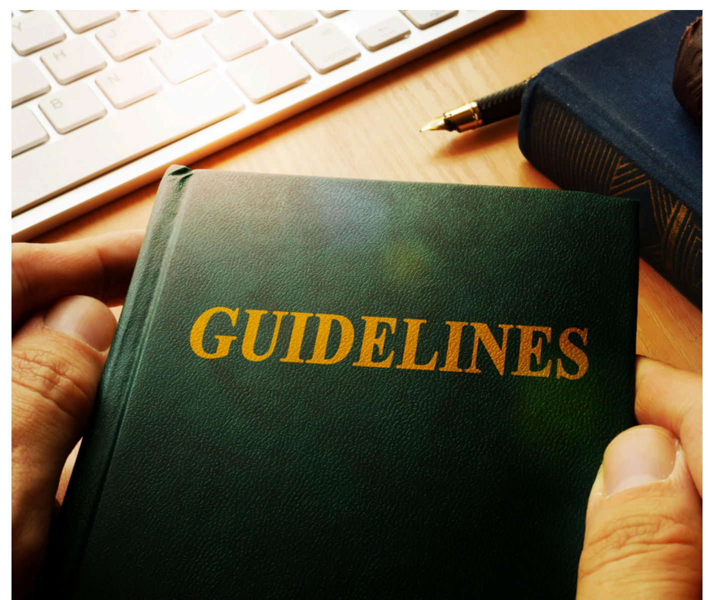

RESEARCH CORNER

Sensory Experiences and Trauma: A Critical Lens for Understanding Psychological Vulnerability

Chloe Golden, Ed.D, MS
Nova Southeastern University

The intersection of sensory processing and psychological trauma represents a critical yet often overlooked dimension of mental health assessment and treatment (Harricharan et al., 2021). Understanding this relationship is essential because sensory differences may shape how individuals experience, encode, and respond to traumatic events, potentially influencing both vulnerability to PTSD and the ways trauma symptoms are expressed. Emerging research suggests that an individual's sensory sensitivity can significantly influence vulnerability to post-traumatic stress disorder (PTSD), particularly among neurodivergent populations such as individuals with autism spectrum disorder (ASD; Rumball et al., 2020). In this paper, sensory processing and sensory sensitivity are used as umbrella terms to describe related constructs that broadly refer to how individuals perceive, regulate, and respond to sensory stimuli.

The Sensory Landscape of Trauma Vulnerability

Recent studies have illuminated the profound connection between sensory sensitivity and trauma risk, with neurological research demonstrating that altered sensory processing is a fundamental characteristic of PTSD, challenging traditional diagnostic approaches that have historically viewed sensory experiences as peripheral to trauma symptoms (Hoffman et al., 2019; Harricharan et al., 2021). This perspective is particularly crucial when considering populations with inherent sensory sensitivities, such as autistic individuals. Prospective studies conducted in high-stress environments have revealed that high sensory sensitivity is a significant predictor of PTSD symptoms, even among allistic (i.e., non-autistic) individuals (Huberman et al., 2020).

Individuals with heightened sensory sensitivity exhibit increased vulnerability to intrusive memories and negative alterations in mood and cognition (Kerns et al., 2015). Studies further demonstrate that functional and structural variability in the sensory processing areas of human brains contributes directly to intrusive re-experiencing of traumatic memories, a core characteristic of PTSD (Fleming et al., 2024). These findings suggest that sensory processing is not merely a secondary characteristic but a core mechanism through which trauma is experienced and remembered.

Autism, Sensory Trauma, and PTSD: A Complex Intersection

Autistic individuals face a particularly complex relationship with sensory sensitivities and trauma (Rumball et al., 2020). Research has consistently shown that autistic adults experience significantly higher rates of PTSD compared to neurotypical populations (Kerns et al., 2020). While some of this increased risk is attributable to higher rates of interpersonal trauma (Reuben et al., 2021), it does not fully account for reports that other events are experienced as traumatic (Haruvi-Lamdan et al., 2018), even when they do not meet current diagnostic criteria. This elevated risk cannot be fully understood through traditional diagnostic frameworks alone and requires a nuanced exploration of “sensory trauma”, a concept that stems from qualitative studies that have revealed a critical insight: autistic individuals often experience lifelong sensory sensitivities that are frequently unaccommodated or misunderstood (Kerns et al., 2022). This persistent sensory incompatibility with the surrounding environment can create a cumulative traumatic burden, in which commonplace sensory experiences become potential sources of psychological distress (Sibeoni et al., 2022).

Sensory Experiences & Trauma (cont.)

Fulton et al. (2020) present several autistic testimonials describing individuals' interactions with the world and a form of distress they identify as sensory trauma. Contributors discussed the physical pain and terror associated with overwhelming sensory experiences, as well as the invalidating responses of caregivers, reinforcing the belief that there is no escape because their need for accommodation will not be recognized or supported. Given the chronic nature of these experiences, the pervasive sense of inescapability, and ongoing invalidation from family, friends, and broader society, these findings suggest that sensory differences in autistic individuals may increase risk for developing complex PTSD (CPTSD).

Future Research: Chronic Sensory Trauma and CPTSD in Autistic Individuals

The emerging body of research points to a critical gap in our understanding of trauma experiences among autistic individuals: the potential role of chronic sensory trauma as a primary mechanism for PTSD development (Rumball et al., 2020). Current research suggests that autistic individuals may have a unique vulnerability to traumatization through sensory sensitivities that are often overlooked in traditional trauma frameworks.

Preliminary studies indicate that sensory processing differences can transform everyday experiences into potentially traumatic events (Fulton et al., 2020; Kerns et al., 2022). The research further suggests that autistic individuals may experience a broad range of life events as traumatic, including unexpected sounds, misunderstandings, and life transitions that neurotypical individuals might not perceive as deeply distressing. Future research must systematically investigate whether sensory sensitivities and repeated distress related to sensory experiences could constitute a distinct trauma pathway for autistic individuals (Harricharan et al., 2021).

Additionally, research needs to more thoroughly explore how trauma symptoms present in autistic populations. Given that trauma exacerbates cognitive rigidity, dissociation, and emotion dysregulation (Rumball et al., 2020), features that are often already present in autistic individuals researchers need to explore when a constellation of experiences reflect a response to trauma rather than an expression of autistic traits.

Clinical Implications

The accumulating evidence demands a shift in trauma diagnosis and treatment. Psychologists must develop assessment protocols that comprehensively map an individual's sensory processing profile, recognize sensory experiences as potentially traumatic events, understand how sensory sensitivity might amplify trauma symptoms, and implement targeted interventions that address sensory trauma experiences. While sensory processing difficulties are often a symptom of PTSD (Kimball, 2023), it is important to assess the duration of these sensory experiences and develop a more thorough sensory processing profile to determine whether these differences predate or extend beyond the intrusive re-experiencing of trauma. In addition, to remain trauma-informed, clinical approaches must evolve to include comprehensive sensory processing evaluations, individualized treatment strategies, interdisciplinary collaboration, and the creation of trauma-sensitive environments that minimize interactions with sensory experiences that trigger a trauma response. Clinicians should collaborate with clients to develop therapeutic environments that are not experienced as overwhelming or distressing.

Conclusion

Understanding trauma through a sensory lens represents a critical advancement in psychological practice. By recognizing sensory experiences as fundamental to trauma formation and recovery, clinicians can develop more nuanced, personalized approaches to healing. Trauma is not only a psychological experience but also a deeply embodied, sensory phenomenon that requires sophisticated, individualized understanding.

Sensory Experiences & Trauma (cont.)

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CULTURE CORNER

Cultural Considerations in Trauma Treatments for South Asian Women Who Experienced Sexual Assault

Shalet Punnoose
Kayleigh N. Watters, PhD
Palo Alto University

Sexual assault is a prevalent and deeply harmful issue in South Asian communities, where women face disproportionately high rates of violence and revictimization (Rai & Choi, 2021; UN Women Asia and the Pacific, 2018). Repeated sexual victimization can result in complex posttraumatic stress disorder (CPTSD), which includes symptoms such as emotion dysregulation, negative self-concept, and relational difficulties (World Health Organization, 2019). For South Asian women, the development of complex trauma is shaped not only by the frequency and interpersonal nature of the abuse but also by cultural norms that demand silence, uphold family honor (*izzat*), and impose shame (*sharam*) on survivors (Gill & Harrison, 2019; Mafura & Charura, 2021). These pressures often discourage disclosure, hinder access to support, and isolate survivors, especially when combined with institutional mistrust and cultural stigma (Bhuyan & Mell, 2020; Harrison & Gill, 2018). Although evidence-based treatments such as cognitive processing therapy (CPT) are widely used for trauma recovery, they often fail to address these cultural dynamics. This newsletter will explore how such treatments may fall short for South Asian survivors of repeated sexual assault and will emphasize the need for culturally responsive adaptations.

Barriers to Treatment for Sexual Assault

South Asian women disproportionately experience sexual assault at rates higher than the global average (UN Women Asia and the Pacific, 2018). Prevalence rates range from 11% to 85.2% (Rai & Choi, 2021; Vasudevan et al., 2022) and revictimization is common (Bhuyan & Mell, 2020). These repeated experiences can lead to CPTSD, which requires sustained, trauma-focused treatment (World Health Organization, 2019). However, there are several barriers to seeking help and engaging in treatment for South Asian women. Survivors often avoid formal services due to stigma surrounding mental illness, concerns about confidentiality, and fears of bringing shame to their families or communities (Harrison & Gill, 2018; Sable et al., 2006). For those who do enter therapy, the clinical setting and process can feel incongruent with their cultural context because providers may lack cultural competence or may misinterpret trauma-related behaviors within a Western individualist framework.

These barriers directly affect participation in treatment and long-term outcomes. Trauma-focused therapies such as CPT require clients to explore and challenge core trauma-related beliefs (Watkins et al., 2018). However, when treatment models overlook the cultural, relational, and community-based dynamics that shape a survivor's distress, therapy may feel disconnected from their lived experience (Gill & Harrison, 2019; Harrison & Gill, 2018). This can lead to disengagement, dropout, or even re-traumatization, especially when survivors perceive that their cultural identities are misunderstood or pathologized (Bhuyan & Mell, 2020). Without addressing these systemic and cultural barriers, even evidence-based treatments risk being inaccessible or ineffective for South Asian women recovering from sexual trauma.

Cultural Considerations (cont.)

Relevant Cultural Factors in South Asian Communities

In South Asian communities, there are pervasive cultural values, such as collectivism, which emphasize loyalty and obedience (Shariff, 2009). Loyalty in South Asian communities prioritizes the needs of the family over those of the individual (Shariff, 2009). This emphasis on loyalty contributes to social expectations of that is based on self-sacrifice and obedience towards one's elders (Shariff, 2009). These dynamics reinforce the cultural concept of *izzat*, which refers to family honor and which women specifically are expected to uphold (Mafura & Charura, 2021). Within this system, women are socialized from an early age to adhere to expectations that prevent their families from experiencing *sharam* (shame; Sangar & Howe, 2021). This can result in strict control over how women dress, what relationships they form, and even their future goals, as they are expected to align with social norms (Peart, 2012).

As a result, when women experience sexual assault, it is conceptualized as a threat to *izzat*, pressuring survivors to remain silent out of fear of bringing dishonor to their families (Gill & Harrison, 2019). Consequently, stigma and victim-blaming may occur, discouraging survivors from reporting their experiences and seeking mental health support (Gill & Harrison, 2019). This dynamic can lead women to internalize their distress, increasing vulnerability to mental health issues (Mafura & Charura, 2021).

Remaining silent may contribute to a cycle of revictimization, particularly when survivors are met with disbelief or blame upon disclosure (Bhuyan & Mell, 2020; Reavey et al., 2006). This revictimization is the result of family members actively working to protect the perpetrator, especially when the abuser is someone close to the survivor, to avoid public shame and preserve the family reputation. This concealment reinforces the cultural pressure to remain silent and discourages survivors from seeking support. This may result in repeated exposure to both the trauma and the abuser, increasing the likelihood of complex posttraumatic stress symptoms (Cowburn et al., 2014). Examining the dynamics between collectivist pressure, relational betrayal, and cultural silencing illustrates how cultural norms influence the likelihood of disclosure and seeking help. These dynamics also deepen the psychological toll of abuse, reinforcing the need for trauma- informed, culturally responsive care (Talwar et al., 2024).

Cultural Consideration for CPT

CPT is an evidence-based, trauma-focused psychotherapy that helps survivors identify and modify maladaptive thoughts (i.e., "stuck points") related to their trauma (Watkins et al., 2018). While the treatment is considered gold-standard, it lacks cultural considerations that specifically apply to South Asian values. The concepts of *izzat* and *sharam* pose challenges to the application of CPT among South Asian women. Since CPT focuses on identifying and restructuring stuck points, cultural values can influence the types of beliefs survivors internalize and may create barriers to engagement (Watkins et al., 2018).

Common stuck points that women might have after experiencing sexual assault revolve around the theme of guilt (Botsford et al., 2019). From a culturally informed perspective, however, shame in many South Asian cultures is externally imposed, and women may believe these messages to be true. For example, beliefs such as "I have brought shame upon my family," or "I have dishonored my parents" (Gill & Harrison, 2019) function as common stuck points. This poses a challenge because externally imposed shame makes cognitive restructuring difficult when it is embedded in cultural values and not just individual thought patterns.

Although CPT is an effective trauma treatment, its individualist approach does not account for cultural constructs of honor and shame that shape trauma recovery among South Asian women. Because CPT relies on cognitive restructuring of personal beliefs, it is harder to address trauma when shame is imposed by family and community expectations rather than solely internal guilt. Thus, to make CPT more accessible, culturally adapted interventions are necessary to address the intersection of trauma, honor, and social stigma in treatment.

Cultural Considerations (cont.)

Recommendation

To improve trauma recovery outcomes for South Asian women, it is critical to develop and deliver treatments that address both the psychological impact of sexual assault and the cultural values that shape survivors' experiences. While CPT is effective in reducing PTSD symptoms, its individualist focus often fails to consider externalized shame and collectivist pressures that discourage emotional disclosure (Gill & Harrison, 2019; Watkins et al., 2018). Culturally adapting CPT to include discussion of family-based expectations, honor-based distress, and culturally specific expressions of trauma may improve engagement and retention. Therapists should incorporate cultural humility and frame cognitive restructuring in a way that acknowledges both individual and community-based sources of distress (Bhuyan & Mell, 2020). It is also important to recognize that increasing therapeutic engagement and improving treatment outcomes begins within the community. Therefore, continuing psychoeducation and community wide engagement within South Asian communities to reduce stigma towards mental health and sexual assault is imperative.

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SURVIVORS' CORNER

Beyond Willpower: Understanding Obesity as a Complex Trauma Response

Lori Herod, EdD
NovaSense, PhD (pseudonym)

We are both survivors of complex relational trauma in childhood—one a professor and scientist, the other a retired professor of adult education, and we have both struggled with our weight. We met on the forum Out of the Storm and soon realized that we both had questions about obesity which caused us to pivot from *Why can't I manage to deal with my weight?* to *Does my childhood abuse play a role in this, and how so?* We decided to review the literature and found research suggesting that obesity is a common complex trauma response that is not only psychological, but also physiological in nature. Findings from the Adverse Childhood Experiences (ACEs) Study (Felitti et al., 1998) and subsequent research (Amiri et al., 2024; Danese & Tan, 2014; Koball et al., 2024; Wiss & Brewerton, 2020) identify obesity as a common outcome of abuse and neglect in childhood. There is science behind this, something we will discuss in this article in hope that healthcare professionals will understand that obesity is not simply the result of psychological harm leading to emotional eating.

When Your Body Becomes the Evidence

We thought it was important in this article for us to share our stories as complex trauma survivors who struggle with obesity. As such, we have each included our story in which we reflect on what happened and why our past makes more sense to us in terms of our weight now.

NovaSense's Story

I don't remember a time when I wasn't overweight. I also don't remember a time when I felt seen.

My mother was unmarried and living under chronic stress throughout her pregnancy with me—with fear, relational conflict, and her own unresolved trauma. I was born underweight, and within days my body compensated rapidly, a pattern the nurses noted but didn't recognize as a stress response. Before I took my first breath in the world, my nervous system was already adapting to signals of threat.

The pattern is evident in family photos—my narcissistic father is never holding me nor looking at me. He's only looking at my sister—his mirror image and golden child. I was not an acceptable reflection, so he simply turned away. My overwhelmed mother tried to compensate. She fed me when I cried. Food became her way of soothing, connecting, and showing love—perhaps because the emotional co-regulation I needed was beyond her capacity.

By elementary school, my body became visible evidence that something was wrong, and the bullying began. Throughout my pre-teenage years, my father sent me to the hospital for enuresis and put me on restrictive diets—diet pills and sweets thrown in the toilet. At ages twelve and fourteen, my parents sent me to weight-loss camps. Nothing worked long-term. The weight stayed, and with it came the message: I was failing at the most basic task of controlling my own body. The deeper burden was invisible: chronic emotional neglect, parentification, and enmeshment with my mother. I learned early on that my needs didn't matter and that my job was to manage her emotions—there was no space for a self to form.

The pattern followed me into adulthood. I tried every diet, consulted countless doctors, and absorbed decades of advice about willpower and portion control. My body didn't respond the way it *should*. I could function on minimal sleep, work through exhaustion, and ignore fatigue, but I also couldn't reliably feel hunger or satiety. The disconnect was profound, though I didn't have words for it then. I believed I was high-functioning—a scientist, a professor—but what I didn't understand was structural dissociation: the *apparently normal part* that functioned in the world was cut off from the *emotional part* that carried decades of unprocessed fear, shame, and grief (Van der Hart et al., 2006). I had no internal sense of safety, no secure base, and a body that had learned to override its own signals.

Beyond Willpower (cont.)

Through it all, I carried the same question: “What is wrong with me?” It wasn't until age 56, after re-traumatization broke through my defenses, that I was diagnosed with complex post-traumatic stress disorder (CPTSD). Only then did I begin to ask a different question: “What happened to me?”

Understanding this reframed everything. My obesity wasn't a personal failure. It was a symptom—one of many—of profound attachment injury, chronic developmental trauma, and a nervous system that learned to survive by disconnecting from itself. The body keeps score (van der Kolk, 2014). And mine started keeping score long before I had the words to name what was happening.

Lori’s Story

My childhood was fraught with tension and anger as far back as I can remember, so it is likely that I was subject to a cocktail of stress hormones even in the womb. My father was an alcoholic, and my mother was a covert narcissist; they fed off each other's dysfunction throughout my life. Both were very critical of me, although not of my weight. My mother loved to cook and bake. She, my father, and I were overweight from as far back as I can remember. I’ve always thought that my overeating was simply emotional in nature—a self-soothing response in the face of constant stress, abuse, and neglect. Food was a buttress of sorts against the shattering of self which I experienced on an ongoing basis. I do remember loving all the “wrong” things—sugar, salt, fat, and carbs—they made me feel better. What I did not realize is that the trauma I experienced basically hardwired me to crave these things.

I was able to manage my weight as a young adult through aerobics and smoking; I smoked instead of eating. Unfortunately, things went south when within the same year in my late twenties I had an accident skiing, hurt my back quite badly and had to quit aerobics. I also quit smoking at the same time because my husband and I were starting our family. Between quitting smoking, being unable to exercise because of my back, and being pregnant, the weight piled on. I got a gastric band when my son was 3 years old and lost about 50 pounds, but then I started to gain weight again. Alongside my shame over this failure was the question, *What is wrong with me that I am gaining weight even with a gastric band?* This shame persisted until very recently, when I began to understand that obesity is one of the ways that trauma manifests in survivors—stemming from physical, not just psychological, injury.

This article is about recognizing obesity as an injury, understanding its origins, and moving the conversation from blame to biology, trauma-informed treatment and care, and dignity.

The Biology Rarely Taught

Many healthcare professionals lack training in CPTSD and ACEs (Berman et al., 2023; Brand, 2016; Goldstein et al., 2018; de Boer et al., 2022; Henning et al., 2022; Tan & Dube, 2021; Yehuda & Lehrner, 2018). In mental health fields, despite the prevalence and impact of societal trauma, few clinicians are well-trained in trauma assessment and treatment (Henning et al., 2022), much less its underlying biology. Similarly, despite decades of evidence documenting the significant health effects of childhood trauma, ACE research remains poorly integrated into medical curricula (Tan & Dube, 2021).

This is what we wish clinicians understood: obesity in complex trauma survivors is not merely about the food choices made in adulthood. It's about how chronic stress, beginning in early life, can fundamentally alter stress biology, metabolic regulation, appetite signaling, and the nervous capacity to detect safety (Rosenthal et al., 2016). For decades, we carried shame for an invisible injury we didn't cause. The harm of that—compounded by judgment from strangers, doctors, family, and ourselves—is what we are finally beginning to name.

Studies of Holocaust survivors' children and pregnant women who experienced the 9/11 attacks show that parental trauma can leave biological imprints on offspring including an altered stress response system (Yehuda & Lehrner, 2018) and metabolic changes (Koball et al., 2024), which have been observed to persist across the lifespan. When chronic maternal stress disrupts the developing hypothalamic-pituitary-adrenal (HPA) axis *in utero* (Yehuda & Lehrner, 2018), it can cause lifelong changes in how the body processes stress, regulates appetite, stores fat, and signals hunger and satiety (Amiri et al., 2024; Koball et al., 2024).

Beyond Willpower (cont.)

In addition, obesity presents a unique challenge that differentiates it from other trauma-related struggles. Unlike alcohol or nicotine, food cannot be abstained from entirely—it is biologically essential and required daily. This creates a distinctive burden: trauma survivors with obesity face food constantly. Every meal, every social gathering, and every grocery trip demands decision-making from regulatory systems that are already compromised by developmental trauma. Some research shows that willpower is a finite, depletable resource (Baumeister et al., 2024; Simons et al., 2021). For those whose satiety signals, appetite regulation, and impulse control were shaped by chronic stress and translates to dozens of complex negotiations daily—each drawing on limited capacity. The cumulative nature of complex trauma alters brain reward systems, making highly palatable foods neurobiologically compelling, and simultaneously impairing the executive function needed to resist those foods—a pattern some researchers describe as food addiction. This represents a trauma-based coping mechanism rather than a conscious choice (Wiss & Brewerton, 2020). The common advice to just eat less ignores the reality that the very brain systems needed for self-regulation are impacted by early trauma.

The impact extends far beyond individual cases. Multiple independent meta-analyses show that ACEs are strongly associated with adult obesity. Exposure to any ACE is typically associated with 1.3-1.5-fold higher odds of obesity, and higher ACE counts (≥ 4) are associated with approximately 1.5-2.0 times higher odds compared to individuals with no ACEs (Amiri et al., 2024; Danese & Tan, 2014; Felitti et al., 1998). These are substantial effects, comparable to those seen with major public health exposures such as low socioeconomic status in cardiovascular disease. For those with the highest ACE counts (≥ 6), the risk increases to 2.5-3 times that of individuals with no ACEs (Felitti et al., 1998). This reflects a graded, dose-response relationship between ACE exposure and obesity risk—not merely a simple correlation, but a clear pattern in which greater trauma predicts higher risk (Amiri et al., 2024). This happens through well-established biological mechanisms: chronic dysregulation of the HPA axis, altered reward processing and emotion regulation, sleep disruption, autonomic imbalance, and early developmental programming that impacts eating patterns and metabolic regulation across the lifespan (Amiri et al., 2024). Additionally, chronic activation of the HPA axis contributes to glucocorticoid resistance and chronic inflammation, which can damage hormone receptors and promote resistance to leptin and insulin—thereby compounding metabolic dysregulation (Koball et al., 2024).

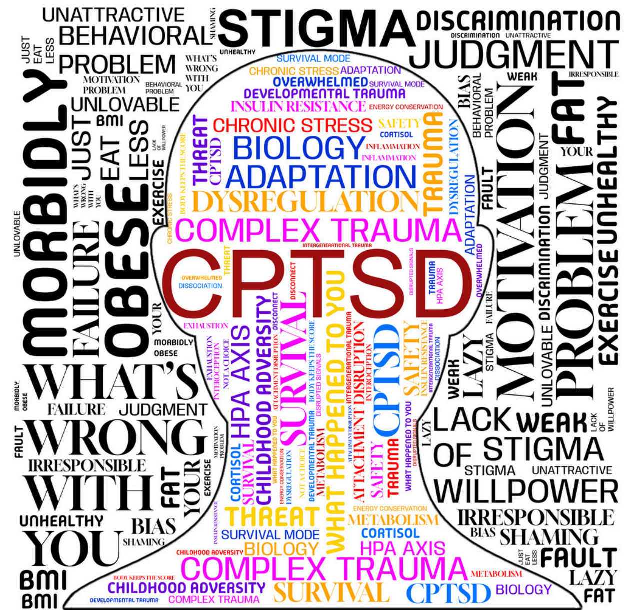
This is what we need clinicians to understand: when you see obesity in a complex trauma survivor, you are often seeing injury, not indulgence. The research is clear and the mechanisms are well-established. For many of us with CPTSD, weight is not a willpower issue but a long-term biopsychosocial consequence of early adversity. For example, telling someone whose interoceptive system is disrupted to listen to your body's hunger cues is akin to telling someone who is deaf to try harder to hear. The signal may not be there or it's so distorted that it can't be trusted.

This is the biology that is rarely taught in medical school or mental health programs (Berman et al., 2023; Brand, 2016; Goldstein et al., 2018; de Boer et al., 2022; Henning et al., 2022; Tan & Dube, 2021; Yehuda & Lehrner, 2018). When clinicians don't know about this, many mistake survival adaptations for moral failures and the harm compounds. Ultimately, this perpetuates and deepens shame and stigma.

Interrupting Shame and Stigma

These biological realities—metabolic programming, interoceptive disconnection, and a nervous system running on override are invisible. What people see is our body. For decades, that visibility has invited an unrelenting stream of judgment, commentary, and unsolicited help, which contributes to a deep sense of shame and stigmatization. The cultural assumptions are pervasive and automatic: people with obesity are lazy, undisciplined, uneducated, and lacking self-control. These stereotypes often operate automatically and can shape judgments instantly. They appear in hiring decisions, medical interactions, and casual comments from strangers. The narrative is so pervasive that survivors internalize it, coming to believe they are the moral failing society projects onto them.

This is the pattern we need clinicians to recognize to interrupt shame and stigmatization: trauma survivors with obesity don't just carry the biological consequences of early stress.



We also carry the social, medical, and mental health consequences of a world that often mistakes our injury for a character flaw (Rosenthal et al., 2016). What we deserve—what every survivor deserves—is the truth that our body's dysregulation reflects injury, not moral failure. Instead, in too many instances we have received blame, dismissal, and compounding shame and stigmatization. Every comment and every unsolicited piece of advice activates the same threat-response systems that were dysregulated by childhood trauma (Tomiyama et al., 2018), creating a feedback loop in which stigma worsens the very symptoms it claims to address. This is why recognition matters so profoundly: not as something extra, but as an interruption of harm.

Interrupting Harm

Language

Recognition begins with language. Language shapes reality. For trauma survivors with obesity, the words used in clinical settings often compound the very harm they claim to address (Mental Health Coordinating Council, 2022).

Consider the term *morbid obesity*. While the medical term derives from the Latin *morbus* (meaning disease), to most patients the word morbid connotes death or deadly—and that's how it lands. It was and often still is used by many clinicians to describe the most severe form of obesity (body mass index [BMI] ≥ 40), even though the World Health Organization’s ICD-11 now uses the more neutral Class III obesity. Further, the Centers for Disease Control and Prevention (CDC) explicitly advises health professionals: "By using clinically accurate terms such as 'Class III obesity' instead of 'morbid obesity,' providers can create a more supportive environment for patients with obesity" and can "help reduce weight bias and stigma" (CDC, 2024). But in practice, this hasn't filtered into everyday care. Many of us still read morbidly obese in our charts or walk into appointments to hear the doctor refer to us using this term. The term is needlessly stigmatizing, embedding judgment and shame into diagnosis—even when that's not the clinician's intent. Class III obesity still communicates medical risk, but it doesn't add new wounds.

Another term we often hear is *emotional eating*, a phrase so ubiquitous it's rarely questioned. On the surface, the term appears compassionate, sending the message: You eat because you're sad or stressed. For complex trauma survivors, however, this framing erases the biology and infers a lack of psychological regulation (Rosenthal et al., 2016). It reduces metabolic dysregulation, interoceptive disruption, and survival-mode energy conservation to a problem of emotional management—as if willpower and better coping skills could override a nervous system shaped by years of complex trauma. Healthcare professionals need training in how trauma physically alters the body, not just to inform their treatment, but to help patients understand the connection between traumatic stress and obesity.

Beyond Willpower (cont.)

Research gathering stories from 390 people about trauma-inducing healthcare experiences reveals consistent patterns in how clinical language harms (Treisman, n.d.). Patients are labeled noncompliant when treatments don't work for bodies operating under different physiological rules—called not trying hard enough after lifetimes of fighting. Marked as difficult patients when they ask questions or challenge reductive explanations (Mental Health Coordinating Council, 2022). These terms do more than describe, in some cases such as morbid obesity they tend to assign moral meaning. Clinical language operates as shorthand, collapsing complex causation and shaping how we are seen, whether we are believed, and whether we continue to seek care at all (Tomiyama et al., 2018).

Research on trauma-informed language shows that word choice matters profoundly (Mental Health Coordinating Council, 2022). People-first language (i.e. saying "person with obesity" rather than "obese person") is a start, but it's not enough if the clinical framework still treats weight as the primary problem rather than as a symptom of deeper injury (Mental Health Coordinating Council, 2022). Recovery-oriented language emphasizes dignity, collaboration, and recognition of context. The question *What happened to you?* instead of *What's wrong with you?* can shift an entire clinical encounter.

or many trauma survivors, language is visceral. It lives in our bodies. When a doctor writes morbid, most of us will carry that word home in shame. When we're labeled noncompliant, we internalize it as one more proof of failure. When our complex physiology is reduced to emotional eating, we lose access to understanding what might explain—and address—what's happening.

What we need from clinicians is language that creates space for complexity: language that recognizes obesity in complex trauma survivors as a symptom of nervous system injury, not a behavior problem; language that invites collaboration, not compliance; and language that asks, What does your body need to feel safe? instead of, Why can't you just eat less? Because when language shifts, treatment can shift. And when treatment shifts, harm is interrupted and healing begins.

Breaking the Cycle

Understanding obesity in complex trauma survivors requires seeing not just the injury, but also the system that perpetuates it. Trauma alters biology. But what happens next—the social, medical, and cultural responses to that altered body—creates a feedback loop that makes healing nearly impossible.

Here's the cycle: trauma dysregulates the body and changes biology → the body gains weight → visibility invites scrutiny → scrutiny activates shame → shame triggers more dysregulation → dysregulation can lead to withdrawal → the cycle continues.

Research shows that experiences of weight stigma are associated with increased cortisol reactivity and metabolic changes that promote further weight gain (Schvey et al., 2014; Tomiyama et al., 2018). Shame doesn't motivate change; it deepens the biological pattern it claims to address. Over time, the cost of being seen becomes unbearable. Many of us avoid medical appointments. We stop seeking help. Survivors report feeling "dread and tension before I have to go to any appointment" (Treisman, n.d.). We shrink our lives to minimize exposure. Social isolation increases, support networks erode, and the very resources that might buffer trauma—connection, safe relationships, collaborative care—become inaccessible.

This is what clinicians often miss if they do not understand complex trauma and trauma-informed care: the intervention itself can become part of the trauma. Every weigh-in without consent or context. Every dietary recommendation delivered without asking about trauma history. Every reductive explanation that erases complexity. The patient leaves feeling dismissed and misunderstood. The shame deepens. The cycle is perpetuated. This is the cycle in which we are trapped. It persists partly because clinicians don't know about complex trauma, but also because some actively choose not to engage with it even when patients name it. Treating symptoms while refusing to address causes may feel simpler or safer, but for trauma survivors, it perpetuates the very dysregulation it claims to treat. Until clinicians are willing to ask, *What happened to you?*—and listen to the answer—healing remains out of reach.

Reframing - From Shame to Science to Dignity

For decades, we have carried the story we were told: This is your failure. You lack discipline. You lack willpower. That story positioned our bodies as evidence of moral failing.

But that story was wrong.

Both clinicians and patients need to reframe obesity. That is, obesity in complex trauma survivors is not emotional eating or a lack of discipline. It is how trauma-adapted nervous systems and bodies behave. It's what happens when: early childhood stress dysregulates the HPA axis; early attachment disruptions teach a developing nervous system that the world is unsafe; chronic threat rewires metabolism to prioritize immediate survival; and, interoceptive pathways are disrupted, leaving survivors unable to reliably sense hunger, satiety, or fatigue.

Obesity isn't a character flaw. It reflects a body shaped by injury, and it deserves a fundamentally different and more humane response than a body shaped by choice.

Ask about early trauma, not just current eating habits. The most important question isn't *What do you eat?* It's *What happened to you?* Trauma history—particularly early childhood adversity and attachment disruption—provides essential context for understanding why a body might operate in survival mode. As daunting as this may seem for some professionals, there are ways of asking patients about a history of complex trauma that are not retraumatizing or intrusive. For example, see “The CARE Method of Screening for ACEs: How and Why to Ask Adult Patients about Childhood Adversity”: https://www.youtube.com/watch?v=fc7NBdCYUAE.

Recognize metabolic and interoceptive dysregulation as injury, not moral failure. When a trauma survivor says, “I don’t feel hunger,” believe them. When metabolic testing shows resistance to standard caloric restrictions, recognize it as evidence of adaptive physiology. These patterns aren't problems to be corrected through willpower. They are injuries that require trauma-informed intervention alongside evidence-based treatment.

Consider medications to help patients. For trauma survivors with obesity, such treatment may include medications like GLP-1 agonists, which research shows can produce significant weight reduction and metabolic improvement. Yet insurance coverage for these medications is routinely denied—not based on medical need, but on cost and stigma. We don't deny chemotherapy to lung cancer patients because they smoked. We don't withhold cardiac medications because someone has high cholesterol from a poor diet. But for obesity, medications may be framed as optional, cosmetic, or evidence of personal failure rather than medical necessity. This is not evidence-based medicine. This is discrimination and it compounds the very harm that created the injury in the first place. Every trauma survivor with obesity has already internalized decades of shame. When clinical interactions add to that shame through weight-focused language, judgmental tone, or reductive explanations, they don't motivate change. They deepen the threat response and reinforce the very dysregulation they aim to address.

Frame weight as a symptom to understand, not a behavior to correct. For complex trauma survivors, weight is often a downstream consequence of upstream injury. Effective care asks: *What does this body need to feel safe?* or *What would help this nervous system regulate?* These questions open pathways that the words like eat less, move more cannot.

Provide trauma-informed care (TIC). TIC creates a relational context in which healing becomes possible—where shame is replaced with curiosity, judgment is replaced with recognition, and the question shifts from *What's wrong with you?* to *What happened to you, and how can we address it together?*

This approach won't erase decades of metabolic adaptation, but it interrupts the cycle, stops compounding harm, and creates the conditions—safety, collaboration, understanding—in which bodies that have spent lifetimes in survival mode might finally begin to trust that something different is possible.

Beyond Willpower (cont.)

An Invitation

We are 57 and 69 years of age. Together, we have lived more than a century in bodies shaped by trauma, bodies that have been scrutinized, judged, and misunderstood for decades. For most of those years, we carried shame we didn't deserve. We believed our bodies were evidence of personal failure.

It wasn't until we encountered the research on complex trauma, the ACEs study and the neurobiology of stress and metabolic adaptation that we began to understand this was never about us. This was about what happened to us, before we had words, before we had choice, and before we had any power to protect ourselves.

That understanding didn't erase the harm, but it interrupted the cycle of shame. As small as it may seem, that interruption opened a door we didn't know existed.

To Those Who Work with Trauma Survivors

We wrote this because we believe understanding—by both survivors and the medical professionals who treat them—can interrupt harm. When you understand that obesity in complex trauma survivors is often a biological consequence of early injury, not a lifestyle choice, it changes what becomes possible. It changes the questions you ask, the language you use, and the space you create for healing.

We are not asking you to have all the answers. We are asking for you to see the complexity, to consider that what looks like resistance might be protection and what looks like failure might be a body doing exactly what it was trained to do: survive. Recognition doesn't require specialized training. It requires a willingness to ask *What happened to you?* instead of *What's wrong with you?* It requires understanding that shame activates the very dysregulation you hope to address. Above all, it requires believing us when we say: obesity is an injury, not a choice.

To Our Fellow Survivors

If you recognize yourself in these words, if you have carried shame alongside the weight, or if you have tried everything and been told it's still not enough, we want you to know this: you are not broken or weak, your body adapted to survive. That adaptation has likely been painful, isolating, and profoundly misunderstood but it was never a failure. The shame you carry is not yours to keep. It was handed to you by a world that didn't understand trauma. You deserved better. You deserve better now. Understanding the biology won't make the struggle disappear, but it offers something we were denied for too long: a different story. A story where your body's responses make sense and where dignity replaces judgment. Healing may not mean weight loss, but it can mean safety, connection, and self-compassion. The slow work of learning to trust that your body—despite everything—still deserves care. You are not alone and you are not too late.

In Closing

We hope that this article has shifted how you understand the relationship between trauma, biology, and the bodies that carry both.

We hope that you will help interrupt the cycle for the people in front of you now, for survivors who struggle with obesity and never understood how much their past trauma impacted their bodies, and for the children just beginning to learn what their bodies will carry.

Because every person with complex trauma and obesity deserves what we were denied for too long: to be seen and heard, to be understood, and to be met with dignity instead of judgment.

Understanding doesn't erase 57 years, or 69, or a lifetime, but it interrupts the cycle—and that is where healing begins.

AUTHOR NOTES

NovaSense, PhD (pseudonym), is a professor and scientist who was diagnosed with CPTSD at age 56. This article represents her shift from shame to understanding, grounded in both lived experience and scientific evidence.

Lori Herod, EdD is a retired professor of Adult Education, survivor of complex relational trauma with CPTSD, founder of the online forum Out of the Storm, and was Co-Chair of the ISTSS Complex Trauma Special Interest Group for three years.

Beyond Willpower (cont.)

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Get in Touch

Have questions, ideas, or want to get involved with the Complex Trauma SIG? We'd love to hear from you. Reach us anytime at complextrauma.sig@istss.org and a member of our team will be in touch.

AUTHOR NOTES

NovaSense, PhD (pseudonym), is a professor and scientist who was diagnosed with CPTSD at age 56. This article represents her shift from shame to understanding, grounded in both lived experience and scientific evidence.

Lori Herod, EdD is a retired professor of Adult Education, survivor of complex relational trauma with CPTSD, founder of the online forum Out of the Storm, and was Co-Chair of the ISTSS Complex Trauma Special Interest Group for three years.

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