Increasing Awareness of Physiological Symptoms of C-PTSD: A Qualitative Analysis

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Abstract

Complex trauma has unique impacts on survivors, distinct from what is commonly seen in post-traumatic stress disorder (PTSD). Complex post-traumatic stress disorder (C-PTSD) has additional diagnostic criteria beyond what is seen in PTSD and has further implications for impacts to the physical self. This study uses secondary data analysis to further increase awareness of the physiological symptom presentation of C-PTSD. The parent study was a mixed-methods, scale development study completed by the first author with support from the second author. The parent study conducted qualitative interviews to generate items for a scale to measure C-PTSD symptoms. The resulting scale then went under psychometric testing to analyze reliability and validity of the scale. During this parent study, it became apparent that physiological symptoms of trauma were heavily prevalent within both the interview and psychometric testing samples. The current study reviews descriptive data from the parent study to show physical symptoms as a result of complex trauma are as equally present as other diagnostic criteria in a sample of 187 individuals who completed a survey exploring symptoms. The current study also analyzes interview data from the parent study using a phenomenological approach to gain deeper understanding of physical symptoms. Themes identified in the qualitative analysis include elevated stress response, pain, disconnection, and disregard for the physical self. Results of this study highlight the importance of integrating the presence of physiological symptoms into therapeutic approaches to ensure best clinical practice.

Keywords

Complex post-traumatic stress disorder, C-PTSD, trauma in the body, physiological symptoms, embodied experience, elevated stress response, pain, disconnection, disregard for physical self

Complex trauma is characterized by the experience of “prolonged, repeated trauma” such as chronic abuse or neglect that occurs inside of intimate relationships (Herman, 1992). Complex trauma can also occur in the context of social conditions such as racism, gender discrimination, and living in a war zone, among others (Amsalem et al., 2025; Cénat, 2023; Herman, 1992; Kira et al., 2015). Complex trauma differs from single traumatic experiences in the impact it can have on survivors and the subsequent requirements for effective treatment (Cloitre, 2021).

Those who have experienced complex trauma types have been shown in clinical literature to live with symptoms unique to their experience. These differences have been established in diagnostic criteria between post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (C-PTSD), as currently outlined by the International Classification of Diseases, eleventh edition (ICD-11) (World Health Organization, 2022). Diagnostic criteria for PTSD include symptoms of avoidance, intrusion or re-experiencing, and hypervigilance, all occurring after experience of a traumatic event. C-PTSD criteria states that an individual should meet criteria for

PTSD with additional symptoms of challenges in affect regulation, interpersonal relationships, and self-concept (World Health Organization, 2022).

While these diagnostic criteria have proven to be fairly comprehensive, and inclusion of C-PTSD into the ICD-11 has been a victory for visibility of this disorder, physical symptoms are missing from criteria. Experiences with both single/isolated and complex trauma types have been shown to lead to ongoing physiological symptoms for survivors (Bracha, 2004; Levine, 1997; Sullivan et al., 2018, Tyagi et al., 2016; van der Kolk, 2006). Impact of trauma on the body has further been shown to lead to lasting physical challenges later in life. Those who have experienced adverse childhood experiences (ACEs), for example, have been studied to suffer higher rates of chronic illness, cardiovascular impairment, and pain (Felitti et al., 2019). Trauma has been shown to impact various systems, leading to ailments such as gastrointestinal dysfunction, increased cortisol levels, reduced grey matter volume in the frontal lobe and, importantly for the context of the current paper, dysregulated experiences with interoception or body awareness (Begemann et al., 2023; Schaan et al., 2019).

Awareness of complex trauma's impact to the physiological self has grown in recent years, but there remain gaps in understanding how physical symptoms manifest and the interventions best suited to address complex trauma holistically. Embodied therapeutic practices such as yoga, dance, weightlifting, and others have emerged to address the physiological impact of complex trauma (Gray, 2017; Kelly et al., 2021; Nowakowski-Sims, et al., 2023; Price et al., 2017). Additional approaches in integrating somatic work with cognitive and talk approaches have also proved to be efficacious in addressing trauma (Carson et al., 2022). Continuing to increase awareness of the impact, prevalence, and manifestation of physical symptoms of trauma can add to this growing body of literature as well as help support the development of effective interventions. It is important that clinical practices integrate the mind-body connection in their approach.

This study uses data gathered from a scale development study focused on C-PTSD to further highlight the manifestation of physical symptoms for those with complex trauma histories. The parent study created a comprehensive scale for C-PTSD symptoms by expanding on the International Trauma Questionnaire (ITQ) to include physical symptoms. The current study uses interview data to better understand how complex trauma survivors experience physical symptoms in their everyday lives. As our knowledge of C-PTSD symptoms continues to expand, clinical approaches can be better tailored to meet the needs of survivors.

Physical symptoms experienced as a result of trauma

Though trauma theory emerged with Freud's late-19th-century works, expansion on symptom presentation and what is classified as trauma have developed through the decades. The physical manifestation of trauma is an area that has been more comprehensively studied and explained in recent years. Trauma has been found to alter nervous system and brain activity, leading to disturbance in cardiovascular function, respiratory system performance, and activity in the digestive system (Bracha, 2004; Levine, 1997; Sullivan et al., 2018, Tyagi et al., 2016). Additionally, if someone experiences a trauma "trigger," or reminder of a traumatic event, survival instincts increase, altering brain activity (van der Kolk, 2006). This causes increased energy in the sympathetic branch of the nervous system, resulting in decreased heart rate variability, increased respiratory rates per minute, and slow digestive function (Sullivan et al., 2018; Tyagi et al., 2016). Other systems of the body can experience further dysfunction; for example, the adrenal system may release high amounts of cortisol, the stress hormone (Sullivan et al., 2018). The body has been seen as a vessel for physically responding to trauma recall (Carson et al., 2022).

Polyvagal theory (PVT) is viewed as an additional construct to the neurophysiological impact of trauma. This theory, developed in 1995, posits that the vagus nerve and corresponding pathways are also impacted by trauma and cause impaired responses in the body (Porges, 1995).

Polyvagal theory further explains trauma's impact to the sympathetic nervous system and how this alters a person's social engagement system (Porges, 1995). This theory is of particular importance to C-PTSD due to the impact to a person's interpersonal relationships as result of complex trauma. PVT continues to be used as a framework for exploring common symptoms linked to trauma disorders, such as gastrointestinal dysfunction and unexplained changes in cardiac and respiratory function (Kolacz et al., 2019).

While certain physiological markers can be measured in clinical settings, this is not always feasible. Interoceptive theory offers a perspective of physiological symptoms in clinical practice. Interoceptive theory emerged from the field of neuroscience in the early 2000s. Pioneers such as Alan "Bud" Craig (Craig, 2003) and Antonio Damasio (Damasio, 2000) have postulated in various ways both that human beings have a coherent neurological architecture that transfers sensory information from the viscera (the body extremities, muscles, and organized tissue) in toward the central nervous system, and that this system as a whole—termed interoception—has a profound impact on our sense of self and our experience of moving through the world. As the field has progressed rapidly and with great vigor over the past decade, other researchers have postulated that traumatic experiences can impact our capacity for interoception in various ways (Reinhardt et al., 2020).

Our hypothesis is that surviving complex trauma may pull people's attention away from their embodied experience and toward the external environment. Another way to say this is that it is more effective to survive by paying attention to what threats may or may not be present in your external environment as opposed to staying connected to your internal states. In this way, you do your best to take evasive action or, when that's impossible, to protect yourself through dissociation or other skillful means. Because of the priority of external information for survival of relentless trauma, a person subjected to these conditions may not get to practice interoception with much consistency, which may lead to dysregulation in the neurological pathways that constitute the interoceptive system. In our view, a significant amount of suffering associated with the impact of complex trauma may be related to elements of dysregulated interoception, contributing directly to things like self-harm, chronic dissociation and depersonalization, self-medication, and even a pattern of recreating traumatic relationships as one moves forward through life because one might not have reliable access to such things as "gut feelings" when danger is present, especially when that danger is embodied in another person (Cook et al., 2003).

Embodied practice in clinical settings

The emergence of non-cognitive, body-first approaches to treating trauma can be understood as an iterative process over the past several decades that has resulted from an evolving understanding of trauma and its impacts. The stories we tell about ourselves are one way we get to know ourselves and explain ourselves to others, but we don't only exist in language and stories. We also exist, and get to know ourselves, as embodied entities, physically interacting with each other and our environment at all times. Our selves are impacted by all of these experiences, many of which can't be put into language. While parts of us are having experiences and fitting them into a narrative about who we are, what the world is, what other people are to us, etc., other parts of us are having experiences that don't interact with language, that don't become incorporated into our narrative regarding who and what we are, and that don't become part of the stories we tell about ourselves. Traumatic experiences in particular appear to leave deep imprints on our entire organism—for which there are literally no words (van der Kolk, 2015). This gap between language and experience has highlighted the need for clinical interventions that go beyond a cognitive approach. Several embodied practices have risen in popularity due to their efficacy in addressing physiological components that are missing from cognitive therapies.

One specific treatment that has become available over the past couple of decades is Trauma Center Trauma-Sensitive Yoga (TCTSY). Utilizing physical shapes and grounded in a

hatha yoga style, TCTSY is an evidence-based, body-first intervention for trauma and PTSD (Emerson, 2015). Some of what distinguishes TCTSY from more mainstream yoga classes is the use of invitational rather than directional language; an emphasis on the choices available rather than aiming for a specific outcome with each shape; an absence of physical, hands-on assists; and, importantly, a focus on the potential interoceptive experience in the moment one encounters each shape. Yoga approaches in clinical settings have proven to be efficacious due to engaging the nervous system in a more comprehensive way. This allows for relief from neurophysiological symptoms, increased interoception, and, in some cases, a quicker decline in PTSD symptoms than cognitive approaches alone (Kelly et al., 2021; Niles et al., 2018; Price et al., 2017).

Other embodied clinical practices have been found to be effective for also bypassing cognitive techniques' mechanisms for healing. Dance movement therapy, for example, allows the nervous system to experience multiple emotional states swiftly, but in a safe and controlled environment (Fox, 2025). This then translates to improvement in emotion and affect regulation. Additional themes of embodied clinical practices include an increased sense of safety, increased personal empowerment, and increased awareness of emotional states (Gray, 2017). As we continue to deepen our understanding of physical manifestations of trauma, we can further advance therapeutic approaches that address these symptoms.

Methods

The current study analyzes descriptive and qualitative data specific to physiological symptoms of C-PTSD from a parent study (Bennett, 2024) to give further insight to the prevalence, impact, and presentation of physiological symptoms. The scale developed in the parent study (Bennett Expansion to the International Trauma Questionnaire [BE-ITQ]) is made up of 37 items designed to comprehensively capture the symptoms experienced by those with complex trauma histories, who may meet diagnostic criteria for C-PTSD. This parent study used qualitative analysis results to inform the creation of scale items, which were then added to the existing ITQ (Cloitre et al., 2018). The final scale was then tested for reliability and content validity. Exploratory factor analysis results yielded six subscales in this instrument, labeled "self-concept and interpersonal relationship," "PTSD symptoms," "affect regulation," "self-awareness," "physical symptoms," and "conflict avoidance," respectively. Appendix A shows the items included in this scale.

Two samples were used in this parent study. The descriptive data is drawn from the sample used for psychometric testing. This sample included 187 participants who identified as being over 18 and having histories of complex trauma. Since the goal of this phase was psychometric testing, a larger sample was needed. Recruitment for this sample was done through flyers distributed to several organizational listservs that are involved in trauma research or reach populations that are more likely to have experienced complex trauma. Recruitment flyers clearly defined complex trauma, and participants had to certify via survey questions that they experienced complex trauma before answering questions regarding symptoms experienced. All recruitment and data collection was completed in 2024. Participants then rated the impact of the symptoms captured in the 37 items on the BE-ITQ.

Table 1. *Demographic data of psychometric testing sample (*N=*187)*

		N	**%**
Race	Asian	5	2.7
	Black or African American	4	2.1
	Hispanic or Latino	4	2.1
	Multi or Bi-Racial	5	2.7
	Native American or Alaska Native	3	1.6
	Pacific Islander	2	1.1
	White	161	86.1
	A race or Ethnicity not listed here	3	1.6
Gender	Cisgender female/woman	152	81.3
	Cisgender male/man	13	7.0
	Genderqueer, non-binary, or gender fluid	18	9.6
	Transgender male/man	1	0.5
	A gender not listed here	1	0.5
	Missing/did not respond	2	1.0
Age	18-25	15	7.7
	26-32	32	16.3
	33-40	54	27.6
	41-48	44	22.4
	49-56	38	19.4
	57-64	7	3.6
	65-72	4	2.0
	73+	2	1.0

Interviews were conducted during the parent study to gain deeper insight into what symptoms might be presenting for those with complex trauma histories. The purpose of these interviews in the parent study was to generate items to include in a scale for C-PTSD. This current study revisits this qualitative data with the purpose of focusing on physiological symptoms of complex trauma. Available data from this phase of the parent study consists of transcripts of 12 interviews with participants above 18 years of age and identified as having complex trauma histories. Demographic data for the interview sample can be found in Table 2. For this qualitative phase, the first author ensured the focus of the interview in the parent study was not to process participants' trauma, but rather to discuss the impact each trauma history had to daily life. Before each interview, recruitment materials in the parent study clearly defined complex trauma to ensure inclusion criteria was met before moving forward with the interview process. Recruitment for this phase of the parent study was done through snowball sampling, social media, and past research study participants in this area of interest that had agreed to be contacted again for future study opportunities. All qualitative interviews were conducted via Zoom and recorded for transcription purposes. Transcriptions were then de-identified and video recordings deleted to protect participant confidentiality.

Table 2. *Demographic data of qualitative sample (*N=*12)*

		N	**%**
Race/Ethnicity	White	8	66%
	Mixed Race	1	.08%
	Latin American	2	16%
	South Asian	1	.08%
Gender	Cisgender Female	7	58%
	Cisgender Male	2	16%
	Non-Binary	3	25%

Due to the sensitivity of the subject matter discussed in this parent study, mental health resources were provided in both the qualitative and survey administration stages. The parent study was approved by the Indiana University Institutional Review Board (#18835).

Descriptive Data

Descriptive analysis and corresponding results used data collected in the parent study that was focused on psychometric testing of the scale. SPSS 29 was used for analysis. To begin looking at physical symptoms reported separate from other symptoms of complex trauma, summary scores were computed for each of the six subscales in the BE-ITQ. Averages of the subscale summary scores were then computed to gather descriptive data on the average response for each subscale. From here, mean values were compared to analyze prevalence of physiological symptoms with the five other subscales. A Likert scale was used in the parent study that allowed each participant to rate how impacted they were from each item. The scale responses were 1=not at all, 2=a little bit, 3=moderately, 4=quite a bit, and 5=extremely.

Qualitative Analysis

The parent study used thematic analysis to develop themes that captured symptoms experienced from complex trauma broadly. Interview questions followed diagnostic criteria of C-PTSD as outlined in the ICD-11. The interview guide from the parent study can be found in Appendix B. Despite no direct questions about physical symptom manifestation, discussion of physical symptoms is still present in each interview transcript, which shows the importance of this topic for participants. One participant shared, “so many of my symptoms show up physically... I cannot emphasize enough how much trauma lives in the body.” Another shared, “The physical symptoms of PTSD are just as debilitating as the mental ones, if not more.”

For the current study, interview transcripts were revisited using phenomenological analysis to gain deeper understanding of physical symptom manifestation. Phenomenological analysis is appropriate for this study due to the natural emergence of the discussion of these symptoms throughout the interview process. This allowed the first author to revisit the qualitative data with *epoché* (van Manen, 2016), or an open sense of wonder about the manifestation of these symptoms.

Results

Descriptive data

The parent study found that, among the 187 survey respondents, physical symptoms were experienced as frequently as other diagnostic criteria. Descriptive data analysis was conducted on the responses of the 187 participants who completed all scale items. Subscales were transformed to compute an average summary score for each of the six subscales. Average responses for summary scores show fairly close responses across the six subscales. The mean scores can be compared below (Table 3). Responses in each subscale hovered near 3, indicating not only the prevalence of the symptoms in question, but also a moderate impact to daily functioning from each item. Five items are included in the physical symptoms subscale and are as follows: "I experience chronic pain," "I experience muscle soreness or pain often, not due to physical exertion, exercise, or injury," "I struggle with managing symptoms of a chronic health condition," "I frequently experience abdominal discomfort," "I feel fatigued or have low energy frequently." These scale items addressing physiological symptoms were all formed through qualitative analysis in the parent study and were not previously included in the IQT.

Table 3. *Descriptive statistics of subscale scores among survey respondents (*N=*187)*

Subscale	Number of items	M	SD
PTSD symptoms	10	2.96	0.80
Affect regulation	4	2.84	0.98
Self-concept and interpersonal relationships	9	2.86	0.97
Conflict avoidance	3	3.10	1.01
Self-awareness	6	2.93	0.76
Physical symptoms	5	2.95	0.99

Table 3 shows the comparison of mean scores across all subscales in the survey from the parent study. Findings of this descriptive analysis justify looking deeper into the qualitative data collected from the parent study to gain a deeper understanding of how physical symptoms manifest. While a helpful insight, the descriptive data alone does not provide much depth as to how physiological symptoms may present for survivors of complex trauma.

Qualitative analysis

Qualitative data from the parent study was reviewed using phenomenology to gain rich understanding *(N*=12). The initial step in phenomenological analysis is for the research team to familiarize themselves with the transcript data (van Manen, 2016). Accordingly, the first author began making note of occurrences in which physical manifestation of trauma was discussed, then

the first author organized these occurrences into clustered themes (Moustakas, 1994). From here, the data was analyzed to gather deeper meaning behind the clustered themes, working to identify the "essence" of the participant's experiences (van Manen, 2016). Findings were then organized into themes including: elevated stress response, pain, disconnection, and disregard for the physical self. These themes are used to describe the experience of physical symptoms from survivors.

Though not captured as a theme of physical symptom presentation, it is worth noting that many participants described feelings of being dismissed by the medical community. Participants discussed journeys with chronic pain, auto-immune conditions, struggles with weight and food, disordered eating, trouble sleeping, chronic fatigue, and how they felt these challenges directly connected to their trauma histories. Frustrations were shared of being told they "just needed to lose weight," "were just being anxious," and "needed better coping skills," rather than feeling they were able to receive help from doctors for physical symptoms they were experiencing.

Elevated stress response

Noticing physical changes in the body as a result of trauma triggers was the most prevalent theme from phenomenological analysis. Presentation of physical symptoms in this way was reported in each interview. This theme is expressed by direct physical symptoms reported such as, "feeling shaky," "aware of my breath," "I can feel my heart rate increasing, my blood pressure increasing," "pins and needles feeling and trembling tightness in my chest or throat or stomach," and "fatigue." Participants discussed these symptoms being present in times of stress, recalling their past traumas, or, in some cases, in daily life, feeling their baseline stress levels were significantly higher than appropriate for mundane tasks.

Participants reported that these physical symptoms brought about distress and frustration. One participant described frustrations with feeling a consistent elevated stress response, saying they felt like they were in a "constant state of fight or flight." Another reported feelings of heightened awareness during a stress response: "I can feel like the physical changes happening which is like it, like it's like transformers." This particular participant reported heightened awareness of their physical body only during times of high stress.

Pain

The theme of pain surfaced across four interviews and captured various manifestations as well as frustrations in trying to manage this phenomenon. One participant reported, "I have migraines constantly. I go to the chiropractor, I'm in physical therapy once a month, like I have debilitating back pain and headaches, because my body just won't get out of fight or flight." This experience with pain was identified as being directly related to overall tension and stress in the body that has presented due to the history of complex trauma. Another reports, "I'm in pain every day, and it's impacting my ability to, like, work and concentrate." This participant went on to elaborate how physical manifestations of trauma have impacted cognitive function and often preoccupied this person's mind.

Two participants described more official medical diagnoses that were related to, or causes, of pain that they also identified as being directly connected to their history of complex trauma. One participant reported recently being "diagnosed with an autoimmune disease" after

several years of dismissal from medical professionals. This person reported chronic pain in addition to several other physical symptoms (fatigue, unexplained fevers, trouble eating, etc.) that eventually led to their diagnosis of an autoimmune disease. Another participant reported being "chronically B12 deprived" and connected this to pain in their body. In each of these interviews, the participants discussed specific frustrations with doctors and feeling dismissed.

Disconnection

Disconnection from the physical self was a theme that emerged across three interviews explicitly, though a general disconnection from self was apparent in most interviews. Disconnection can be described as an unawareness of one's personal needs due to being distracted by others as well as actively being disengaged from the self. One participant shared feeling a lack of awareness of themselves due to the experience of "take(ing) care of everyone else's kind of needs, and, you know, ignore(ing) my own." Another shared a similar sentiment by sharing they felt "incapable of, like, taking care of myself... I just, like, am very, very compassionate to other people and dirt to myself." Although prioritizing others' needs over one's own is often understood as a gendered phenomenon, the men interviewed reported a similar disconnect from their own needs and putting needs of others before their own. Both men and women interviewees felt they needed to do this as a means of survival, to appease those who were inflicting abuse.

Two participants shared that they developed unhealthy eating habits that they attributed to a history of complex trauma. One shared they "always kind of used food to cope, but I didn't really realize that that was what was happening." In both occurrences, participants acknowledged a disconnection from their bodily needs as a contributing factor for their eating habits.

Another participant shared that they did not feel connected to their body. This participant described consistently distracting themselves with others tasks, needing to please others as a self-preservation response, and feeling unable to slow down in daily life. This phenomenon was described as feeling "out of control of my body." Further, this participant described a desire to be more intuitive and able to care for themselves, but they stated, "I don't have, like, a gut."

Disregard for the physical self

While I interpreted "disconnection" as a more passive process, surfacing across many domains, "disregard for the physical self" emerged in the interviews as a more active neglect of physical needs. One participant reported, "I'm often, like, choosing to, like, skip meals, or to, like, sleep all day," as they discussed struggling to care for their physical body. This particular participant reported feeling better able to identify and engage with coping skills that addressed mental stress, but they didn't have the same ability to care for their physical self. Another participant reported this disregard for the physical self, saying, "I ignore my body a lot as far as, like, physical pain or I tend to, like, just kind of push past to the point that it's not healthy." Through both of these interviews, participants discussed having knowledge that the way they treated their physical being was not conducive for holistic healing, but they struggled to apply more care to this area of their lives.

Participants discussed the origins of these challenges in caring for themselves as stemming from childhood trauma. In total, seven of 12 participants discussed a theme of disregarding self. Those who grew up in neglectful and abusive environments identified feeling their physical needs were often not tended to, which led to continuing this pattern themselves as adults. One participant reported, “like, the way I was fed and not fed as a child has definitely impacted the way I eat and don’t eat as an adult.” Others shared sentiments that their physical ailments in childhood were disregarded, healthy habits were not taught, and in cases where physical abuse was inflicted, participants were expected to not show signs of distress as result. These phenomena were connected to the disregard for the physical self as an adult.

Discussion

Results from this study highlight the impact of physical symptom manifestation for survivors of complex trauma. This contributes to current literature by giving additional language to what is experienced by survivors. Findings of this study are consistent with what is currently known in the literature regarding physical symptom presentation, particularly hypervigilance and impairment to a person’s interoceptive abilities. Additionally, this study adds to findings in the literature by identifying challenges with chronic pain and other health conditions being disproportionately prevalent for those with trauma histories.

Findings from this study further highlight the importance of continuing to advance the knowledge in the clinical literature regarding the manifestation of physical symptoms for those with trauma histories. Treatment approaches that do not address the physical manifestation of trauma do not effectively address all of a survivor’s struggles. If therapeutic practices do not holistically address survivors’ needs, there are significant gaps in the services being provided.

Future research should be done to continue exploring how physical symptoms manifest across populations. This study has limitations in the size and diversity of the sample. The data used in this study was majority white (66%) and cis-gender female (56%). Few participants identified as minorities. Symptoms could be experienced differently in these underrepresented populations. Expanding on this data with larger and more diverse sample sizes will continue adding to the literature by highlighting what symptoms clinicians should be aware of and addressing in their approaches. Having increased knowledge of physical symptoms can aid in building more effective embodied approaches that are used either in conjunction with or in place of cognitive therapies.

This research, as well as advancements in this line of study, can help practitioners better integrate their therapeutic approaches. Currently, many therapeutic interventions for this population rely on cognitive processing and methods. While this approach is effective in addressing some of the symptoms present after trauma, it does not comprehensively cover all that survivors may struggle with. This is particularly true in cases of complex trauma. Research focused on physical manifestations of trauma and symptoms can inform further practice development to better integrate the mind-body connection.

The presence and impact of physical symptoms for complex trauma survivors have implications for clinical practice by justifying the need for embodied interventions as well as continuing to build awareness of the physical presentations of trauma symptoms. If dysregulated interoceptive abilities are associated with challenges such as self-harm, self-medication, chronic

dissociation, and continued traumatic cycles, then there is an ethical necessity to address these challenges in clinical practice. Continuing research in this area will lead to the development of more effective interventions as well as a deeper understanding of survivors' experiences.

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Appendix A: BE-ITQ

Please read each item below carefully, and mark one of the numbers to the right. The number you select should indicate how much or how intensely you feel impacted by the statement in the last month. The statements refer to ways you typically feel, ways you typically think about yourself and ways you typically relate to others. Answer the following thinking about how true each statement is of you.					
	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Having upsetting dreams that are replaying the experience or clearly related to the experience?	0	1	2	3	4
2. Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
3. Replaying the event while awake?	0	1	2	3	4
4. Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4

5. Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4
6. Being “super-alert”, watchful, or on guard?	0	1	2	3	4
7. Feeling jumpy or easily startled?	0	1	2	3	4
8. Experiencing trouble sleeping	0	1	2	3	4
9. Having an increased awareness of your surroundings	0	1	2	3	4
10. My heart races often (outside of physical activity	0	1	2	3	4
11. Expression of my emotion is often intense (such as emotional outburst, rage, or intense crying).	0	1	2	3	4
12. It takes intense concentration for my to manage my emotions.	0	1	2	3	4

13. My mood states often change quickly.	0	1	2	3	4
14. When I am upset, it takes me a long time to calm down.	0	1	2	3	4
15. Decreased ability to experience positive emotions	0	1	2	3	4
16. Decrease interest in activities once enjoyed	0	1	2	3	4
17. I feel distant or cut off from people.	0	1	2	3	4
18. I find it hard to stay emotionally close to other people.	0	1	2	3	4
19. Maintaining relationships is difficult for me.	0	1	2	3	4
20. I feel like a failure.	0	1	2	3	4
21. I feel worthless.	0	1	2	3	4

22. I feel numb or emotionally shutdown.	0	1	2	3	4
23. I often do not feel safe around others.	0	1	2	3	4
24. I avoid conflict in relationships.	0	1	2	3	4
25. If conflict arises in a relationship, I prefer to address it directly.	0	1	2	3	4
26. I feel I am able to speak up for myself when I feel I have been treated unfairly.	0	1	2	3	4
27. I feel a connection (a feeling of being aware) to my physical body.	0	1	2	3	4
28. I notice when I am having a positive experience in my body.	0	1	2	3	4
29. If I experience something uncomfortable in my body, I can shift my	0	1	2	3	4

awareness to that experience.					
30. I notice when I am experiencing neutral bodily sensations.	0	1	2	3	4
31. I often consider my desires and needs when making decisions.	0	1	2	3	4
32. I can identify activities that increase my sense of connectedness.	0	1	2	3	4
33. I experience chronic pain.	0	1	2	3	4
34. I experience muscle soreness or pain often, not due to physical exertion, exercise, or injury.	0	1	2	3	4
35. I struggle with managing symptoms of a chronic health condition.	0	1	2	3	4
36. I frequently experience abdominal discomfort.	0	1	2	3	4

37. I feel fatigued or have low energy frequently.	0	1	2	3	4
In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:	Not at all	A little bit	Moderately	Quite a bit	Extremely
38. Created concern or distress about your relationships or social life?	0	1	2	3	4
39. Affected your work or ability to work?	0	1	2	3	4
40. Affected any other important parts of your life such as parenting, school or college work, or other important activities?	0	1	2	3	4

Appendix A: Interview Guide from Parent Study

Before we begin collecting information, I would like to review the purpose of this interview and provide mental health support. This interview will be used to deepen the understanding of complex trauma and symptoms that may be experienced as result of this. Information provided in this interview will help inform the development of a scale intended to measure Complex Post-Traumatic Stress Disorder. Though we will not focus on the details of your trauma history, it is possible questions could feel triggering. Please remember you may state you do not wish to answer a question and/or can end your participation at any time. Some mental health resources include:

988- suicide and crisis lifeline

BetterHelp.com- online counseling services with sliding scale options

Psychologytoday.com- online database to find a therapist.

Identifying your local community mental health center

Identifying and spending time with loved ones.

Demographic Questions:

1. How do you identify yourself racially?
2. How do you identify your gender?
3. What is your age?
4. Could you describe your income-level or class identity?
5. What is the highest level of education you have completed?

C-PTSD related questions:

There are several symptoms of C-PTSD that have been studied in survivors. I am hoping to gain insight in to how, if at all, these symptoms apply to lives of survivors. I will briefly describe what each symptom means, and then would like to hear your interpretation of how you experience this symptom. IF something does not apply to you, that is okay as well.

6. Affect regulation is defined as how a person manages their internal experience and external expression of emotions. Can you tell me about your experiences with affect regulation?

Probing questions:

What does affect dysregulation look like?

What does it feel like to be emotionally regulated/dysregulated?

Please describe a time where you needed to communicate your emotions to another.

Please describe a time when you experience an intense emotion, and then try to process or manage that emotion.

7. Self-concept is the idea of how we identify ourselves. This can include things like our self-esteem, our overall perception of ourselves, how confident we feel in decision making, and our sense of connection with ourselves. Can you tell me how this may have been impacted by your complex trauma history?

Probing questions:

Please describe your connection with how you perceive and value yourself.

What are some things that you do that make you feel in touch with yourself?

Please describe times where you felt disconnected from yourself.

How confident do you feel in making decisions independently?

Please describe how you feel about the level of control you have over your life.

How would you describe your self-esteem?

Please describe how you feel when receiving criticism from others.

8. Interpersonal relationships identify the way you connect with others and the stability of these relationships. This can include relationships with family, friends, co-workers, and anyone else you have consistent contact with. How do you feel your interpersonal relationship have been impacted as result of your trauma history?

Probing questions:

Can you describe the level of conflict you feel is present in your interpersonal relationships?

If you experience conflict with someone, how do you typically resolve that conflict?

Can you describe your feelings of trust in relationships?

9. How have experiences of discrimination or systemic injustices impacted your life?

Probing questions:

Can you tell me of any times you have been treated unfairly based on a characteristics of your identify (race, religious orientation, sexual orientation, gender, etc.)?

Can you tell me of any times you have not felt comfortable in larger social situations due to fear of judgement?

Please describe your perceptions of safety in your typical environment.

What do you need to feel safe?

Please describe any experiences you may have had where you felt unsafe based on any of your identity characteristics.

10. Can you please discuss any other areas of your life that have been impacted by your complex trauma history?

*conclude with a review of mental health resources and thank participant for their time