Why am I exhausted, foggy and ill now that I'm safe? Your body waited. It is a bill arriving late.

> **If you are not alone right now, this page will be in your browser history. You can read it in a private window, or clear it when you are done.**

Exhaustion, cognitive fog and new or worsening physical symptoms often appear after an abusive relationship ends rather than during it. A body that has been mobilized for years does not stand down on the day the danger does, and a great deal of what was being suppressed while vigilance was necessary becomes available once it is not. The pattern is documented and the mechanisms are known.

Fatigue, fog and pain are also the first symptoms of a long list of treatable physical conditions — thyroid disease, anemia, low iron or B12, sleep apnea, diabetes, autoimmune illness, perimenopause. **A psychological explanation does not rule any of those out, and nothing on this page is a substitute for a physical examination and blood work.** If you are exhausted and foggy, the first appointment is with a physician. That is not a formality and it is not a way of dismissing you.

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Why does it start now, when the danger is over?

Symptoms surface after the threat ends because the cost of the years of vigilance is paid on a delay, and because the systems that were doing the vigilance do not have an off switch tied to your circumstances. The name for that accumulated cost is **allostatic load** — the wear produced by a body repeatedly adapting to demand, described by the neuroendocrinologist **Bruce McEwen** as the price of stability achieved through change rather than through rest (McEwen, 1998).

The framework is well established and the measurement is not, which is worth knowing before anyone sells you a number. Allostatic load as a *theory* — chronic demand producing cumulative multisystem cost — is mainstream physiology. The **allostatic load index** used to quantify it in research has no agreed definition; studies assemble different biomarkers, and work is still underway to standardize it. So the concept explains your experience. It does not yet produce a test you can ask for.

The delay itself is also recognized in the diagnostic language. The **DSM-5-TR** carries a specifier for posttraumatic stress disorder, *with delayed expression*, for cases where the full criteria are not met until at least six months after the event — an acknowledgment, written into the manual, that arriving late is a recognized course rather than an anomaly or an exaggeration. Whether any of this amounts to emotional abuse causing PTSD is a separate question, and it needs an assessment rather than a page.

Women describing this almost always apologize first. They open with *I know this sounds ridiculous* and then produce a symptom list that would get anybody else a referral and a panel of blood tests. The apology is the residue of years of having ordinary reports treated as complaints.

Why did I not feel any of this while it was happening?

You did not feel it while it was happening because a body under threat actively suppresses the signals that would slow it down. That is not a metaphor and it is not resilience. It is a measurable physiological process with a name: **stress-induced analgesia**, in which endogenous opioid and non-opioid systems dampen pain perception during states of threat, which is why injuries sustained in emergencies are frequently not noticed until afterwards.

The same logic governs attention. Interoception — the perception of what is going on inside your own body — is a low priority for a nervous system whose task is to monitor another person's footsteps. Fatigue, hunger, pain and illness all get downweighted, for years, in favor of a task with a shorter deadline. Living inside what coercive control actually is makes that reallocation permanent rather than occasional.

There is an experimental analogue for what happens when the pressure lifts, and it is small enough that its size should be stated. In a three-month electronic diary study of **17 people with migraine**, producing 2,011 diary records and 110 eligible attacks, a decline in perceived stress from one day to the next was associated with a **roughly five-fold increase in the odds of migraine onset in the following six hours** (Lipton et al., 2014). Seventeen participants is a very small study and it is about headaches, not about you. What it shows is that the phenomenon of a body producing symptoms *when the demand falls* is real, has been measured, and has a name — the **let-down effect**.

If you are reading this and you have not left, none of it requires you to have decided anything. The body keeps this account whether or not the relationship has a name yet.

Is this in my body, or is it stress?

The exhaustion is in your body, and the health literature on this is substantial and good — which is the part almost nobody tells women, because "stress" is used as a way of ending the conversation rather than describing a mechanism. Living under sustained threat changes measurable physiology, and the downstream conditions are ordinary medical ones.

In a retrospective cohort study using **The Health Improvement Network**, a UK primary care database, **18,547 women with a recorded history of intimate partner violence** were compared with **74,188 age-matched women without one** over a study period running from 1995 to 2017. The exposed group had an adjusted incidence rate ratio of **1.73** (95% CI 1.36 to 2.22) for developing fibromyalgia and **1.92** (95% CI 1.11 to 3.33) for chronic fatigue syndrome (Chandan et al., 2021). The absolute numbers are small — 97 fibromyalgia diagnoses among the exposed women against 239 among the far larger unexposed group — and the design is observational, so it establishes association rather than cause. It is also, at ninety thousand women, one of the larger pieces of evidence in this field.

The construct proposed to explain that cluster is **central sensitization**: a state in which the nervous system's processing of pain signals is turned up, so that ordinary input is registered as painful and the pain outlasts

anything that would explain it. Fibromyalgia, chronic fatigue syndrome and several related presentations are grouped under it.

Reporting this literature is precisely where a page like this can do harm, so here is the boundary. An association between abuse and a later diagnosis does not mean your symptoms are a trauma response. It means women with this history get ill more often, which is an argument for being investigated more carefully, not less. If you have been to a doctor and left with "it's probably stress" and no tests, that is an incomplete appointment, and you are entitled to ask for another one.

> **If you are in immediate danger, call 911.**
>
> **National Domestic Violence Hotline — 1-800-799-7233**, 24 hours · text **START** to **88788** · thehotline.org
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> **988 Suicide and Crisis Lifeline** — call or text **988**
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> Deaf, DeafBlind and hard-of-hearing callers: National Deaf Domestic Violence Hotline videophone **855-812-1001**, 24 hours (a partnership between the National Domestic Violence Hotline and Abused Deaf Women's Advocacy Services).
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> Calling leaves the number in your call log and texting leaves the thread in your messages. Both can be deleted afterwards. If that is not something you can do safely, a friend's phone or a payphone is the safer route.

What is the brain fog, actually?

Brain fog is not a haze and it is not a metaphor for feeling low. When it is measured, it resolves into slowing and inaccuracy in specific cognitive domains, and the pattern is consistent enough across studies to be described precisely rather than gestured at.

In a meta-analysis of **60 studies covering 4,108 participants** — people with PTSD, trauma-exposed people without it, and healthy controls — the PTSD group showed an overall medium impairment of **d = 0.49** across nine cognitive domains. The largest deficits were in **verbal learning (d = 0.62)**, **speed of information processing (d = 0.59)** and **attention and working memory (d = 0.50)**; visuospatial and visual memory deficits were smaller (Scott et al., 2015).

Read that domain list against your actual week. Verbal learning is why you cannot retain what was said in the meeting. Processing speed is why the conversation moves on before your answer is ready. Working memory is why you walk into the kitchen and stand there. Those are the exact three things people describe as fog — and in people with PTSD, they are the three that come out largest when somebody measures instead of describing.

The mechanism is a resource problem. **Working memory holds a small number of items and it is the same system that runs threat monitoring.** A person scanning continuously for a change in tone, a car, a mood, a

message is running a demanding background task at all times, and whatever it consumes is not available for remembering where the keys are. Add fragmented sleep and the margin disappears entirely. Fog is what a fully committed attentional system feels like from the inside.

Why is the sleep still wrong?

Sleep stays wrong after leaving because the arousal that made sleep dangerous has not been retired, and because the hours around sleep were, for years, the hours that required the most monitoring. The body learned that night is when the situation changes. It does not unlearn that on a schedule that suits anyone.

The complaints have specific shapes. Falling asleep is hard because lying still in the dark removes every distraction from a mind that has been outrunning something all day. Waking at two or three is hard because sleep lightens in the second half of the night and a system set to detect change surfaces easily. Waking exhausted after eight hours in bed is the signature of fragmented sleep rather than short sleep — and fragmentation is also what obstructive sleep apnea produces, one more reason the physician comes first.

Two things reliably make it worse and both are addressable. If he still generates contact, the monitoring has a live subject and not only a historical one, which is why he still seems to be running your week. And if something is being used to get to sleep, that changes sleep architecture in ways that outlast the drink itself — and what it is doing and what it costs are worth knowing in that order.

What should you actually do about this?

Start with the physician, and go with a list. Fatigue, fog and pain are worked up with ordinary tests, and the conditions that produce this exact picture are common: thyroid disease, iron deficiency and anemia, low B12 or vitamin D, diabetes, sleep apnea, autoimmune conditions, and perimenopause. Ask directly what is being tested and what is being ruled out. **You are allowed to say that you would like this investigated rather than attributed.**

Say the relevant history if it is safe to say it. A doctor who knows there is a history of abuse reads a symptom cluster differently and investigates it more thoroughly. If it is not safe, or if you are not ready, the symptoms still deserve the workup on their own.

Treat sleep as clinical, not as hygiene. Persistent insomnia has effective treatment and it is not a lecture about screens. Ask.

Pace rather than push. The standard instinct — to make up for the lost years by doing everything — reliably produces a crash. **Pacing** means working to a level you can repeat tomorrow rather than to the level you can reach today, and it is among the most useful behavioral changes available here.

Treat the psychological part as a real part, once the medical part has been looked at. The exhaustion, the anger and whatever has been getting you through the evenings are not three separate problems in a queue — they are the same account from a different angle.

What this page can tell you, and what it cannot

This page can tell you why symptoms arrive after safety rather than during danger, what allostatic load is and how far the measurement has got, what the health-outcomes literature establishes about women with this history, and what brain fog resolves into when somebody measures it instead of describing it. **This page cannot tell you why you are tired.** That requires a physician, an examination, and tests — and no article, this one included, is entitled to substitute a psychological story for a diagnosis that has not been ruled out.

One thing worth keeping. You have probably been told at some point that this is stress. Used that way, the word ends a conversation rather than explaining anything, and the accurate version is more specific and more serious: sustained threat produces measurable multisystem cost, and women with this history develop identifiable conditions at higher rates. **Your body waited until it was safe. That is not weakness arriving late. It is a bill arriving late.**

If you want to talk to somebody now, the **National Domestic Violence Hotline** is **1-800-799-7233**, 24 hours, or text **START** to **88788**. For plain-language health information written for women and free of marketing, womenshealth.gov is federal and reliable.

If a therapist is the next step you are weighing, it is worth settling what specialist training in this actually means and what to ask before a first appointment.

You do not have to have decided anything to start. Not leaving. Not staying. Nothing at all.

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