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Exploring the Role of Attachment Trauma in the Complex PTSD Victim's Self-Concept

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Walden University
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Abstract

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by

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MA, Liberty University, 2017

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

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Abstract

Complex posttraumatic stress disorder is a very serious mental health condition with long-term side effects that impact a victim's quality of life. Many studies have been conducted that explore various aspects of complex posttraumatic stress disorder. However, there is a gap in research exploring the role of attachment trauma in the development of self-concept for complex posttraumatic stress disorder victims. This gap is relevant because treatment of this population has been decisively limited and attachment trauma has been found to be a correlate among many psychiatric groups. By identifying how attachment trauma develops self-concept, researchers and clinicians can be better equipped to treat psychiatric populations plagued by the debilitating effects of psychological trauma. The theoretical foundations used in this study are based on the suppositions of attachment theory and posit that secure attachment is necessary for healthy functioning. This was an interpretative phenomenological study that included nine participants with a clinical diagnosis of complex posttraumatic stress disorder. The research question was to understand the lived experiences of C-PTSD victims, and the subquestion was to understand how attachment trauma shapes their self-concept. The findings revealed that participants experienced significant challenges in meta-cognitive skills and endured debilitating symptoms of distress that impacted their perception of self. Implications of this study indicated that attachment trauma has a decisive role in the development of self-concept and could lead to positive social change through impacting treatment modalities for mental health fields.

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Dedication

I would like to dedicate this dissertation to all the victims of complex posttraumatic stress disorder. “From every wound there is a scar, and every scar tells a story. A story that says, ‘I survived.’”- Craig Scott.

Acknowledgments

I would like to thank the wonderful faculty at Walden University with whom I interacted during my tenure. I had the immense pleasure of meeting many professors and distinguished members of the faculty who were critical in my professional development. Specifically, I would like to thank Dr. Eric Hickey for his insights, time, and humor that helped me along the way. I cannot express the amount of gratitude I have for Dr. Julie Lindahl, who has been a lifeline through this seminal project and has striven to keep me focused, encouraged, and engaged. I thank Dr. Bob Meyer for his immense insights, his candor, and willingness to be a part of my committee.

I also wish to thank on a professional level some very near and dear patients of mine who served as the inspiration for this study. Their stories propelled me to explore how their suffering has profoundly impacted them and catapulted this study. The desire to find answers and real-time solutions was inspired by the therapeutic alliances found in the clinical environment. Listening to their stories and realizing that traditional therapeutic approaches would not suffice, fueled the desire for further research. To my precious patients, I thank you for trusting me through this process and for allowing me to hold space with you.

The process of pursuing a doctoral degree is one that requires tremendous patience, willingness and sacrifice. It was always my mother's dream that one of her children would be a doctor. My mother made uncountable sacrifices in my youth, many of which I may not even be aware. My mother is my inspiration for my education, my perseverance, and my desire for excellence.

I want to thank my sister, Samina and my two nieces, Ahlia and Leyla, for always believing in me. Your love and unconditional support have propelled me to heights unimaginable and I could never have reached the heights without your smiles and kind words. I want to thank my sister-in-law, Wanda Upright, who is another sister to me. You have also been a backbone and have encouraged me along the way and kept me focused. I want to thank my "sisters from another mother," Brucetta White and Stephanie Briscoe. Without you two, I do not know how I would have been able to keep my sanity. I cannot forget "Momma D," my dear Delores Burrill, who has been a mentor, my guide, my strength, and my inspiration. I want to thank my son, Jamal Robertson, who always believed in me, took pride in my work, and believed in my causes.

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Chapter 1: Introduction to the Study

Introduction

The study of complex posttraumatic stress disorder (C-PTSD) is one that requires tremendous research and review. There are many aspects of C-PTSD that have been researched and studied since this diagnosis is fairly new to the world of mental health (Cox et al., 2014; Dorahy et al., 2015; Henry et al., 2011). Despite the abundance of studies, there is not presently a published study exploring how the self-concept of the victim of C-PTSD is formulated available. Specifically, there is little understanding concerning the fundamental role of attachment trauma in the integral shaping and formation of the C-PTSD victim's self-concept. There is a significant need for the exploration of the topic I took in this study.

Primarily, from a social aspect, understanding the role of attachment trauma in the formation of the C-PTSD victim's self-concept can provide a fundamental comprehension to the field of mental health concerning pathology, victimology, and symptomology. This study can inform treatment practices, thereby promoting social change in the areas of mental health practices, treatment guidelines, and providing practitioners with more efficacious ways of combatting the deleterious effects of C-PTSD.

This chapter includes a brief overview of the background of the available literature pertaining to the topic of C-PTSD and attachment trauma. This chapter also explores the purpose of this study, the problem statement, the significance of this study,

the research questions that guided this study, key definitions and assumptions, limitations and scope of the study, as well as the theoretical framework that guided the study.

Background

Several studies explored the role of attachment trauma and theory in various aspects of posttraumatic stress and other psychiatric conditions. For instance, Henry et al. (2011) and Ruhlmann et al. (2019) explored the role of attachment trauma in married adults with a clinical diagnosis of PTSD, finding that attachment trauma exaggerated the attachment relationship between married couples. Cukor et al. (2009) provided details of various treatment approaches that were prevalent and effective for PTSD. Ehlers et al. (2010) indicated that bona fide treatment approaches often ignored clinically significant results for the treatment of PTSD symptoms, detailing efficacious treatment approaches with particular notice to attachment modalities. Rokita et al. (2018) discovered that early adverse experiences played a significant role in the development of adult and juvenile major psychiatric disorders. Robert et al. (2018) conducted a study exploring how men with C-PTSD responded to group stabilization treatment and the role of attachment as a subset of the group dynamics. These studies provided substantial information pertaining to the relevant treatment options available for populations of C-PTSD.

Dorahy (2015) determined that populations characterized by C-PTSD often displayed intensified levels of shame and guilt, exacerbating their ability to process cognitive distortions. Jelinek et al. (2010) found that C-PTSD populations accounted for one of the most difficult populations to treat due to the intensity of cognitive symptoms that caused debilitation in recovery. Iverson et al. (2015) conducted a study exploring

how rape survivors' cognitive distortions were impacted after extensive therapeutic approaches. The studies reveal that C-PTSD victims experience severe impact on cognitive distortions. Cognitive symptoms create the greatest cluster of symptoms to treat.

Clifford et al. (2018) conducted a study of individuals with C-PTSD, in which group intervention using emotion and memory processing intervention approaches were used to reduce cognitive symptoms. Varra et al. (2008) conducted a factor analysis of the Trauma and Attachment Belief Scale to measure traumatic stress and cognitive disruptions. Hyland et al. (2014) conducted a study investigating rational beliefs as a protective factor against posttraumatic stress disorder. These studies provide significant literature and information regarding the impact of attachment trauma as well as the implications of posttraumatic stress; however, there is still a decisive gap in the literature concerning attachment trauma and its implications concerning the development of self-esteem for victims of C-PTSD.

Problem Statement

C-PTSD is defined as the repetitive exposure to traumatic events, adverse history of trauma, presence of cognitive symptoms, avoidance, hypervigilance, and intrusive symptoms (Cox et al., 2014). The symptoms of C-PTSD can be debilitating and devastating for a victim. Victims suffer from prolonged symptoms well after the traumatic events have occurred, resulting in significant impairment to overall functionality (Cox et al., 2014). Cognitive symptoms, which are defined as negative beliefs, distrust, attachment issues, maladaptive schemas, distressful/intrusive memories

or flashbacks, dissociative symptoms, shortened sense of future, and self-blame/guilt have been determined to be the most distressful cluster of symptoms to treat in PTSD (Cox et al., 2014). Cognitive symptoms also result in significant impairment in recovery, attachment, resolution of trauma, and restoration of functionality. Henry et al. (2011) determined that victims with a complex history of PTSD and an adverse childhood experienced tremendous difficulty in attachments during marriage and adult relationships. Rokita et al. (2018) found that adults with significant adverse history of childhood neglect, abuse, and sexual assault exhibited symptoms of borderline personality disorder, bipolar disorder, and PTSD. Moreover, victims of C-PTSD experienced agitated responses to their worst moments of trauma, resulting in difficulty maintaining a presence in current reality (Jelenik et al., 2010).

Attachment trauma leads to a compromised sense of self which later leads to diminished self-concept (Rokita et al., 2018). Because attachments form the basis of cognitive beliefs, attachment trauma lays the foundation for faulty cognitive belief systems. Cognitive beliefs are essential in determining one's self-concept; they are rooted in attachment trauma and can create a faulty self-concept (Rokita et al., 2018). Many studies have found that attachment trauma plays a significant role in the complication of PTSD symptoms. For instance, there are numerous studies evaluating how attachment trauma contributes to mental illness, such as borderline personality disorder, schizophrenia, and psychotic disorders, as well as how it impacts relationships in married adults (Henry et al., 2011; Iverson et al., 2015; Robert et al, 2018; Rokita et al., 2018). While various studies have explored attachment trauma, there is a significant gap in the

literature concerning how attachment trauma exacerbates the symptoms of PTSD. Specifically, there is very little known about how attachment trauma shapes the cognitive belief system of a victim and perpetuates the symptoms of C-PTSD.

Purpose of the Study

The purpose of this study was to explore the role of attachment trauma in the formation and development of the C-PTSD victim's cognitive belief system. Attachment theory indicates that a child develops his or her understanding of himself or herself through the role of attachment (Ruhlman et al., 2019). There is very little information or research concerning how attachment trauma shapes the cognitive structure of a victim and how this formation perpetuates the symptoms of C-PTSD. Cognitive symptoms of PTSD are debilitating and without proper understanding concerning how a victim has learned to view the world and his or herself, treatment approaches will be egregiously deficient (Wampold et al., 2010). With this study I intended to address the gap through the use of attachment theory and how attachment may impact a C-PTSD victim's cognitive belief system.

Research Question

Central Research Question: What are the lived experiences of C-PTSD victims?

Subquestion: How does attachment trauma shape the C-PTSD victim's self-concept?

Theoretical Framework

The theoretical framework for this study was Bowlby's (1969) attachment theory, which postulates that caregivers model the attachment style to their infants that will

invariably lead to the attachment style of the infant in adulthood. Bowlby (1969) determined that caregivers who responded in affirmative, secure fashions to their infants developed secure attachment styles in their children who later developed secure attachment styles in adulthood. Caregivers who were inattentive had children who developed avoidant attachment styles and caregivers who were overprotective espoused anxious attachment styles in their infants. A study in attachment theory has been foundational in understanding attachments in adults and has served as the basis for the theoretical framework of many research studies (Fletcher & Gallichan, 2016). Attachment styles form the basis of adult attachment relationships. In C-PTSD patients, attachment styles are distorted and disorganized. This leads to disorganized self-concept. Attachment patterns that are disorganized can lead to anxious styles of attachment, avoidant attachments, or ambivalent attachments (Fletcher & Gallichan, 2016).

Nature of the Study

The nature of this study was qualitative using the phenomenological approach. A qualitative study was appropriate because this study attempted to understand the lived experiences of C-PTSD victims and how attachment trauma potentially shaped and impacted their self-concept (Guillen & Elida, 2019). A phenomenological approach studies the subjective experiences of the participant with consideration to the description, accounts and emphasis to the lived account (Guillen & Elida, 2019). The phenomenological perspective was best aligned with the focus of this research and Bowlby's (1969) attachment theory of how attachments formulate the template for future relationships.

Definitions

The following represent key definitions of terms used in this study.

Ambivalent/Disorganized Attachment: Attachment that vacillates between anxious styles and avoidant styles (Gazzillo et al., 2020).

Anxious Attachment: When a caregiver responds to an infant's needs in an overly concerned fashion consistently the infant learns to attach anxiously, learning that they are unable to care for themselves (Gazzillo et al., 2020).

Attachment Bond: This refers to the emotional connection between the caregiver and the infant (Bowlby, 1969).

Attachment Theory: A theoretical framework and model that describes the intricacies involved with the levels of attachment between a caregiver and an infant and how these attachment styles inevitably impact the psychosocial, emotive, and cognitive development of the infant (Rosmalen et al. 2016).

Avoidant Attachment: When a caregiver is neglectful to an infant's needs repeatedly, the infant learns to avoid attachments (Gazzillo et al., 2020).

Cognitive Distortions/Schemas: Maladaptive beliefs in one's psyche that have become a blueprint for the way the individual views the world and their surroundings (Cox et al, 2014).

Complex Posttraumatic Stress Disorder (C-PTSD): A trauma-related disorder in which the individual displays significant complications with attachments characterized by marked distress in situations that are representative of abandonment or neglect, (Cox et al., 2014).

Internal Working Model: The cognitive model of reality the infant develops based upon the interaction of expectation created between the caretaker's responses to the infant's needs (Riggs, 2010).

Intrusive Symptoms: Symptoms that are uncontrollable and unwanted causing considerable distress and are clinically significant (Cox et al., 2014).

Safe Haven: Another role of the caretaker is to be a place of safety for the infant to return when presented with danger (Rosmalen et al., 2016).

Secure Base: In the Bowlby's theory of attachment, one of the primary roles of the caretaker is to be a secure base for the infant to return to after exploring the world (Rosmalen et al., 2016).

Assumptions

There were several assumptions relevant to this study. Primarily, the key assumptions were that the participants who were involved in this study accurately reported their symptoms and their experiences pertaining to the role of attachment trauma in the development of their self-concept. Another relevant assumption was that I accurately and thoroughly recorded the results and findings for this study. It was also assumed that the interview questions were relevant to the research questions and elicited sufficient data for contributory results. Finally, I also assumed that ethical considerations were applied in this study and all proper precautions were taken due to the sensitive nature of this topic and the vulnerable population that it involved.

Scope and Delimitations

The scope of this study was focusing on how attachment trauma shaped the self-concept of victims of C-PTSD. One delimitation was that the participants were all adults, which could potentially skew results among children and adolescents. Also, this study did not focus on gender or culture-specific issues related to self-concept, which was another significant delimitation. Gender-related issues pertaining to self-concept could shed additional light on how attachment trauma shapes self-concept specifically in gendered and non-gendered populations.

Limitations

Potential barriers included obtaining permission from group sites for participants and potential difficulty recruiting participants for study. Due to the vulnerable nature of the participants, precautions also needed to be taken to ensure that participants' needs were safeguarded pre- and postinterviewing and that they were provided access to supportive services in the event of re-traumatization, such as debriefing, aftercare, and ensuring that participants had adequate access to treatment in case of re-traumatization. Potential ethical concerns included the need to safeguard confidentiality, accessing participants from third-party sources and not from my own caseload, complete disclosure of research purpose to participants, and ensuring that no harm had been enacted upon any of the participants (Andriessen et al., 2019).

Significance

This study may shed light into the way attachment trauma influences how the victim views themselves. The role of attachment trauma in the development of the self-

concept may help mitigate the debilitating effects of cognitive symptoms among victims of C-PTSD (Dorahy et al., 2015). It could also assist clinicians in providing comprehensive care, which might restore cognitive pathways (Wampold et al., 2010). The potential implications for social change include a comprehensive understanding of how attachment trauma may impact adult relationships, correcting parental relationship dynamics, and promoting positive effects in family structures (see Henry et al., 2011). Additionally, generational patterns of relationships may be improved by the understanding of attachment trauma and how attachment trauma alters and shifts the self-concept.

Summary

This chapter focused on providing a background, purpose of the study, limitations and scope regarding the study of attachment trauma and its potential role in developing the self-concept in victims of C-PTSD. The foundation of this study is based upon the concepts and underpinnings of Bowlby's (1969, 1973, 1980) attachment theory and how this theory impacts and shapes the fundamental understanding of human development. While there is significant research pertaining to attachment theory and its role in several psychiatric disorders, there is presently a gap in the literature exploring the role of attachment trauma in the formation of the self-concept in victims of C-PTSD. Chapter 2 explores the relevant literature pertinent to the understanding of attachment theory and attachment trauma. It further explores the literature review related to key variables and/or concepts related to C-PTSD.

Chapter 2: Literature Review

Introduction

C-PTSD is a very difficult psychological ailment to understand and dissect. Individuals who suffer from the effects of this devastating disorder endure years of agonizing and distressful cognitive symptoms that often seem relentless (Cox et al., 2014). The cluster of cognitive symptoms includes hypervigilance, intrusive thoughts, maladaptive behaviors, cognitive distortions, grotesque sense of self, faulty belief system, limitations of reality, negative self-concept, and shortened sense of future (Cox et al., 2014). Victims with complex histories of PTSD experience intense difficulty resolving cognitive symptoms, specifically their faulty sense of self. Because complex trauma traces its roots to adverse childhood history, the development of attachment trauma is a critical component to understand and consider (Rokita et al., 2018). Attachment trauma has been studied and evaluated in its connection to PTSD as it relates to the formation of psychiatric disorders, development of relationships, and other areas of interpersonal dynamics (Henry et al., 2011). However, there is presently a gap in the literature pertaining to how attachment trauma forms and shapes the self-concept of the victim of C-PTSD.

In this chapter, I evaluate relevant literature pertaining to research pertinent to PTSD, C-PTSD, and attachment trauma. The purpose of this chapter is to thoroughly evaluate the available literature in an effort to adequately synthesize the research that has been conducted as well as to identify the gap that is currently present. This chapter provides an expository review of attachment theory and attachment trauma, an evaluation

of attachment trauma in the development of adult relationships, the role of attachment in severe psychiatric disorders in mental health populations, attachment trauma and the development of spiritual self-concept, and relevant treatment approaches for C-PTSD victims. Additionally, I explore the theoretical framework that informed the relevant research studies.

Literature Search Strategy

I used Walden University's Library databases to obtain relevant material. The following databases were accessed in an effort to gain peer-reviewed scholarly material pertinent for this literature review: PsychInfo, SAGE Journals, SocINDEX with Full Text, and Academic Search Complete. These databases are psychology and counseling specific and have been helpful in providing sources that are consistent with the search. Keywords in the search that were used *were complex posttraumatic stress disorder, posttraumatic stress disorder, attachment trauma, attachment theory, attachment theory Bowlby, self-concept,* and *victims*. I focused my literature search strategy on sources and materials that were predominantly conducted and researched within the last 5 years. The focus of the literature search strategy was initially between the years of 2016 to present; however, preceding seminal work was included in this study to demonstrate that there is a significant gap in research regarding attachment trauma and the development of self-concept in C-PTSD populations. Research in this study includes material dated from 1969 to present.

Theoretical Foundation

Attachment theory was first formulated by Bowlby (1969, 1973, 1980) and comprehensively structured with the assistance of Ainsworth (Rosmalen et al., 2016). According to attachment theory, infants, from the moment of birth, require specific responses to their emotional, physical, and psychological needs (Bowlby, 1969). The responses of the caregiver to the infant's emotional, physical, and psychological needs creates a pattern of expectation for the infant that is known as the internal working model. This internal working model is essentially a blueprint or a map for the infant that dictates or allows the infant to predict behavior from self and others. The internal working models, or IWMs, include components that pertain to affect, cognition, defense, reality, and interaction (Riggs, 2010). Parental styles help develop the child's emotional regulation and enhance the child's ability to respond to the parent's patterns of communication (Bowlby, 1969).

When caregivers are responsive to their infants' needs in a nurturing and efficient fashion, infants learn safety and security (Bowlby, 1969). Children develop a secure base that allows them to freely explore the world with the knowledge that they are able to return to their parents' safe haven (Rosmalen et al, 2016). Infants with secure attachments also develop strong a sense of self, formulated from confidence, security, and safety honed from the parental attachment system (Bowlby 1969). The child begins to develop neural networks that assist in the identification of perceiving threat in the presence of danger or deactivation in the presence of security. The role of attachment, therefore,

serves as a survival mechanism for the child based on the principles of evolutionary models.

Contrarily, children who experience unmet needs form insecure attachments that prove to be harmful and deleterious to their formation of self-concept and psychological development. Neglectful or harmful interactions between caregiver and infant lead to disorganized attachment patterns that result in scattered internal working models for the infant (Gazzillo et al., 2020). These scattered IWMs cause multiple maps of reality for the child. In essence, the child has variable channels of possible reality which causes significant confusion, distress and uncertainty. These models are often rigid, unchanging, and unsusceptible to information (Riggs, 2010). This results in psychopathological behavior due to the perception that nothing is predictable and there is no acceptable sense of security. Additionally, the child feels intense sense of anxiety or may exhibit avoidance at the thought of attaching due to the precarious nature of attachment that the child has experienced (Gazzillo et al., 2020). In some instances, the child may vacillate between anxious and avoidant attachment styles. For children who have experienced attachment insecurity, there are three dominant types of attachment styles: anxious attachment, avoidant attachment, and disorganized or ambivalent attachment (Gazzillo et al., 2020). These attachments result from the compromised IWMs of the child and impact interpersonal as well as intrapersonal relationships.

It is necessary to understand that attachment has specific functions: to create and maintain a reliable level of proximity between the caregiver and the infant, to allow the infant to explore the environment while having a secure base, and to provide the infant

with a safe haven if the infant feels any kind of environmental threat or danger (Talley, 2018). Attachment serves the purpose of establishing a firm foundation for the child and adhere to models of evolutionary perspectives of survival and reproduction.

Literature Review Related to Key Variables and/or Concepts

This section discusses the relevant literature that was accessed and used in the synthesis of the literature review process. It provides working definitions of key terms and concepts such as C-PTSD, attachment trauma and adverse childhood experiences. Additionally, this section provides a literature review of concepts pertaining to treatment of PTSD, the role of attachment in psychiatric disorders, the role of attachment trauma in adult relationships, attachment trauma and spiritual relationships, the develop of self-concept, and attachment trauma and its impact on self-esteem.

C-PTSD

Due to the understanding that complex posttraumatic stress is interconnected with attachment turbulence, the IWM of the victim is severely compromised (Riggs, 2010). The severed internal working model impacts core areas of functioning such as cognitive processing, affect regulation, social functioning, impulse control, and dissociation (Pressley & Spinazzola, 2015). Symptoms of C-PTSD range from difficulty in affect regulation, dissociative symptoms, somatic complaints, and significant cognitive distortions (Dorahy et al., 2015). The combination of symptoms, intensity, and frequency in C-PTSD populations are most often greater than in any other psychiatric population due to the substantial adverse childhood experience history and the diminished capability of the patient's coping mechanisms and posttraumatic resilience (Dorahy et al., 2015).

Treatment of C-PTSD

C-PTSD has several intricacies that confound treatment options. From a treatment perspective, the clusters of symptoms deal primarily with the challenges of the victim's self-concept and the defective sense of self (Cox et al., 2014). This belief system is rooted in the attachment system experience of the victim since attachment relationships create the internal working models of the individual (Muller, Sicoli, & Lemieux, 2000; Muller, Thornback, & Bedi, 2012). Treatment approaches, therefore, that focus on targeting cognitive aspects, have emerged to be the most successful in treating the symptoms of trauma (Ehlers et al., 2013). For instance, cognitive behavioral therapy is a very effective form of treatment that helps in challenging the maladaptive schemas of the victim and helps the victim restructure new and adaptive working models (McDonagh et al., 2005). Specifically, trauma-focused cognitive behavioral therapy has been very effective in combatting the deleterious effects of C-PTSD. Another form of cognitive behavioral therapy is cognitive processing therapy, which has also maintained successful results among participants in clinical trials (Ehlers et al., 2013). Both of these forms of therapeutic approaches target the cognitive schemas, maladaptive beliefs, and automatic thoughts of the victim. They systematically rebuild the belief system of the patient and assist in creating a new, adaptive reality that is better suited to provide relief from symptoms.

Cukor et al. (2009) outlined several helpful types of therapeutic techniques such as dialectical behavioral therapy (DBT), acceptance and commitment therapy (ACT), mindfulness, exposure therapy, virtual reality therapy, and pharmacological treatment

options that have proven to have successful results among complex posttraumatic populations. These therapeutic approaches each offer different perspectives and are based on various theoretical models. Mindfulness therapy focuses on enhancing skills that keep the patient in the here and now (Cukor et al., 2009). Since trauma is often associated with past experiences, the premise of mindfulness therapy is that focusing on the present will minimize symptom severity and help the patient resolve traumatic memory. DBT is a form of cognitive-behavioral therapy that challenges the idea of dichotomy, a concept that is prevalent among complex trauma survivors. ACT is a form of therapy that focuses on increasing control of thoughts and feelings and memories (Cukor et al., 2009).

Group therapy approaches also provide tremendous support to victims of complex trauma and help alleviate symptoms while supplying a sense of community, compassion, and understanding (Robert et al., 2018). This alternative to individual therapy can sometimes be a very helpful approach in combatting the stigmatization and isolation associated with traumatic experiences. Finally, desensitization techniques are among the most prominent in treating the effects of trauma. Desensitization and reprocessing techniques such as eye movement desensitization and reprocessing (EMDR) function in phases by desensitizing the traumatic memory and reprocessing the memory into a positive cognition (Wampold et al., 2010). EMDR has statistically significant results in reducing traumatic incidences among clinical studies and has proven to be a very efficacious form of treatment along with various forms of exposure and desensitization techniques. The various approaches outlined all target the debilitating effects in effective

ways and alleviate the cognitive symptoms, thereby providing significant relief to C-PTSD victims.

Bowlby (1980) observed that treating patients with attachment trauma required a fundamental understanding of the devastating impact that the severed attachment relationship had upon the individual. In his clinical observations, Bowlby learned that patients exhibited various forms of distress, depression, and disorders. In fact, loss and separation was cause for clinically significant disturbance that was characterized as either psychotic or neurotic (Bowlby, 1979). This is an indication that traumatic experiences create patterns of distress that can be debilitating. Although C-PTSD was not a diagnosis at the time of Bowlby's observation, it is clear that implications for treatment include attachment concerns. Comprehensive treatment of C-PTSD must deal with the intrusive cognitive symptoms and these symptoms are apparently a result of the internal working model created through the shattered attachment in the childhood experience (McDonagh et al., 2005). The victim of C-PTSD suffers greatly from the effects of the trauma and the lingering messages of the traumatic experiences. Cognitive distortions, belief systems, and impairments plague the victim's thought-life. Stress levels increase at a considerable rate, altering the composition and chemistry of the brain (Ross, 2016). Victims of C-PTSD are often, from a neurobiological perspective, incapable of halting these stressful thoughts and flashbacks on their volition. This further intensifies feelings of helplessness, hopelessness, and worthlessness.

It is important to note that in the treatment of complex trauma, the focus is not merely the reprocessing of the traumatic events. Rather, it is the complete restructuring of

the victim's self-organization that is required to take place in order for therapy to be considered successful (Karatzias et al., 2018). This entails the systematic deconstruction of the victim's faulty self-concept and rebuilding of a healthy cognitive self that is based upon the processed traumatic memories, cognitive distortions, and maladaptive beliefs. In this regard, the most efficacious treatment approaches are those that are phase-based and focus on establishing a therapeutic alliance with the victim, healing the attachment insecurity housed in the victim's psyche, addressing cognitive maladaptive schemas, and processing traumatic associations (Parra et al., 2017). Phase-based approaches provide the victim with time to slowly repair the damage from a lifetime of traumatic experiences while also giving the victim ample opportunity to properly attach to the therapist, who in most cases would be the first safe person the victim has ever met (Parra et al., 2017). The process of correcting negative cognition is a prolonged phase-based therapeutic approach and requires patience, dedication, and a particular skill that is necessary for proper and effective treatment protocol.

Attachment Trauma

Attachment applies to cradle to grave, marking all significant life points in between. Bowlby (1980) was able to delineate the connection between attachment and pathology by analyzing how attachment develops over time and the risk factors that impede the cognitive processes in the social and emotional development of the child. In his initial study, Bowlby (1969) determined that infants when removed from their mothers (or caregivers) and placed with strangers would exhibit significant distress and agitation. They would cry incessantly for their caregivers' return and when this need was

not met, the infants would become despondent. Bowlby (1980) observed that eventually, the infants became apathetic, withdrawn and inconceivably miserable. This observation demonstrates that the responses of caregivers form a decisive imprint on infants' attachment patterns.

Adverse Childhood Experiences

Adverse childhood experiences poignantly impact the development of attachment in individuals. Chalfin and Kallivaylil (2017) surmised that patients who displayed chronic suicidality reported high levels of adverse childhood experiences and developmental or attachment trauma. Chalfin and Kallivaylil (2017) found that chronic suicidality became a circular experience of acquiring their needs; the child learned that their needs would not be met and learned to rely on not having needs met as a way of having them met. Suicidality resulted as a response to environmental pressures, as a last resort, as well as a tempest for highly traumatized populations. Additionally, Chalfin and Kallivaylil (2017) identified that intrafamilial violence, neglect, and complex trauma were among the most devastating forms of adverse childhood experiences that often resulted in chronic suicidality. The central theme of Chalfin and Kallivaylil's (2017) findings support attachment theory and validate the conceptual underpinnings of Bowlby's work. Adverse experiences result in damaged sense of reality and can cause psychological challenges that are deleterious to the child's overall development. Bowlby (1980) identified that loss and separation were key factors in suicidality among depressed patients. He surmised that the inconsolable urge for the absent parent manifested in several ways such as disconnection from self, punishment toward the absent parent, or a

cry for help (Bowlby, 1980). This disconnection from self stems from the attachment trauma experienced in the caregiver and infant dynamic.

Similarly, Bosqui et al. (2017) explored attachment security in adolescent populations exposed to warfare. They believed that attachment trauma would perpetuate the recovery of posttraumatic stress and exacerbate hostility in adolescent populations exposed to armed conflict in occupied Palestinian territories. Study results indicated that insecure attachment styles were directly correlated with high levels of posttraumatic stress and hostility (Bosqui et al., 2017). These findings are consistent with attachment theory presuppositions for example, situations such as warfare can result in loss of caregivers at a young age. This developmental trauma can prove to be undeniably damaging for children, resulting in significant mourning and unsatiated yearning for the lost parent (Zelenko & Benham, 2002). Bowlby (1980) indicated that when young children lost a primary caregiver, the loss was inconceivable and resulted in complete despair. This despair caused substantial loss of emotional regulation, affect control and sense of purpose.

Solomon et al. (2008) conducted a similar study exploring the effects of posttraumatic stress disorder on attachment among former prisoners of war (POWs). They contended that patterns of attachment remained relatively stable over time which implied that patterns in personality should also remain stable over time. Their hypothesis was that former prisoners of war suffered complex trauma which decidedly impacted personality, thereby impacting attachment. They conducted a study using a control group and a group of former POW survivors to examine the effects of posttraumatic symptoms

and attachments. The findings indicated that the POW group suffered from higher levels of anxious and avoidant attachments as well as higher reports of posttraumatic stress symptoms in comparison to the control group three decades after the imprisonment (Solomon et al., 2008). Results indicated that trauma deeply impacted attachment significantly after the trauma had occurred. The foundational underpinnings of attachment theory are supported by these findings as well. Traumatic events shape attachment styles as Bowlby (1969) surmised in his theoretical assumptions. The exposure to attachment disturbances in early relationships impede the progression of healthy constructs that result in high levels of anxious and avoidant attachment styles throughout the life cycle (Bowlby, 1969).

Utilizing Bowlby's (1969) theory of attachment, Anderrson (2015) evaluated the overall integrity of attachment in adult Finnish combat veterans and war children with a PTSD diagnosis. Anderrson (2015) espoused that parental attachment exacerbated the progression of PTSD symptoms. The premise of this study was to determine if attachment would compound the symptoms of PTSD with the understanding that the IWMs of the individual were compromised by the parental attachment structure. Separation and bereavement complicated the psychopathology of Finnish evacuees, placing them at increased risk for PTSD symptoms. Anderrson (2015) found that detachment was higher in groups where separation with the primary caregiver was a factor. Evacuees also showed higher levels of distress in symptoms, decreased attachments, low self-esteem, and higher levels of attachment trauma. Anderrson's (2015) findings corroborated Bowlby's (1969) theory of attachment by supporting the

concepts that separation from primary caregivers results in disorganized attachment. Prolonged separation results in increased stress, anxiety, and overall impaired attachment.

Adverse childhood experiences can include a variety of traumatic encounters such as intrafamilial violence, armed conflict, psychological abuse, sexual abuse, and neglect. At the core of each experience or account, the child is seeking a sense of safety and is experiencing a breach of trust, betrayal, intimacy, safety, control, and esteem (Varra et al., 2008). Chronic violence, trauma, and abuse may also lead other complications such as delinquency, transience, and psychopathology (Schrader-McMillan & Herrera, 2016; van der Hart, 2018). These experiences distort the child's sense of reality and compromise safety, security, and attachment. Repeated trauma and experiences of abuse can even alter the neurobiology of the victim, resulting in alterations of six core domains of functioning: impulse and affect regulation; attention and awareness; self- perception; relationship with others; somatization; and systems of meaning (Perez et al., 2020).

Role of Attachment in Psychiatric Disorders

In his clinical and research work, Bowlby (1980) learned that in situations of prolonged or chronic separation and bereavement, children and infants began to display significant pathological behavior that was indicative of psychiatric illness. For instance, children whose caregivers were either deceased or persistently absent due to divorce of separation displayed heightened symptoms of depression, anxiety, and chronic suicidality. Bowlby (1980) surmised that attachment turbulences caused by extreme separation, death, or neglect contributed significantly to the increase of psychiatric illness among patients.

Adverse childhood experiences may include death, separation, neglect, and/or abuse. Adverse life experiences have been determined to be the leading risk factors for severe psychiatric disorders, specifically schizophrenia-related disorders, borderline personality disorders, dissociative disorders, posttraumatic disorders, major depressive disorders, anxiety-related disorders, and antisocial personality disorders (Rokita et al., 2018). This predisposition to psychiatric disorders may be the result of several factors. For instance, children exposed to considerable trauma and abuse in their developmental years are often unable to develop appropriate and suitable coping mechanisms that may assist in posttraumatic resilience, rendering them particularly susceptible to traumatic experiences and psychiatric conditions throughout development (McNally, 2003).

Additionally, traumatic and adverse experiences have been known to change neuroanatomical structures and functions, which are intrinsically connected with attachment, emotional regulation, cognitive functioning, social development, intrapsychic and interpersonal relationship, affect recognition, and mood stabilization (Farina et al., 2019). Adverse experiences impede the development of the hippocampal and frontal cortex of the brain, which may result in decreased empathy, difficulty with attachment, increase in psychosis, dissociative features, neurological deficiencies, decreased social-cognitive skills, and overall heightened anxiety and avoidance symptoms (Garcia et al., 2016; Schalinski et al., 2018). Bowlby (1980) found that many psychiatric populations displayed a known history of separation from caregivers and adverse childhood history, indicating a correlation between mental illness and developmental trauma.

Beeney et al. (2015) theorized that attachment security was the basis for social-cognitive disturbances found in specific disorders such borderline personality disorder, antisocial personality disorder, and avoidant personality disorder. They surmised that borderline personality disorder symptoms were characterized by high levels of anxious and avoidant attachment styles; these were entrenched in intense fears of abandonment, neglect, and rejection. These fears were based in traumatic experiences exacerbated by chronic loneliness, identity disturbances, and shattered internal working models. Conversely, antisocial personality disorders and avoidant personality disorders were characterized by detached or withdrawn attachments, damaged internal working models that communicated lack of safety and security, and decreased empathy.

Pos et al. (2015) explained that theory of mind refers to all aspects of mental state such as cognitive beliefs, thoughts, and intentions about self and others. Theory of mind and attachment connections begin to develop early in infancy and these associations become permanent through childhood experiences. Pos et al. (2015) found a statistically significant association between theory of mind and attachment disturbances in patients displaying psychotic disorders versus their siblings and control groups. These findings are consistent with many research studies pertaining to attachment trauma and psychiatric disorders. For instance, a study conducted by Lysaker et al. (2011) revealed that patients with schizophrenia-related disorders displayed significant difficulties recognizing their own emotions and the emotions of others, a condition known as alexithymia. The study results indicated that patients in psychiatric populations characterized with a history of chronic abuse, neglect, and attachment issues reported challenges in identifying emotions

such as sadness, anger, and disappointment. Further, children with attachment trauma history displayed difficulty processing their own emotions and identifying facial emotions (Russo et al., 2015). This is due to the inability in expressing emotion, understanding emotion, and organization of coherent thought. Emotional regulation, conceptual understanding of self and others, and resilience are factors that become significantly impaired in groups exposed to abuse, maltreatment and neglect (Powers et al., 2015).

Bowlby (1980) found an apparent connection between attachment and psychiatric disorders. He ascertained through his theoretical model that attachment trauma impacts the development of the brain in core areas that pertain to social, emotional, and cognitive functioning. These core areas drive the neuro-mechanisms of the individual and contribute to pathological behavior, metacognitive beliefs, social-cognitive skills, and affect regulation. Depression disorders were among the first to be observed in Bowlby's (1980) studies among attachment trauma populations. Posttraumatic populations are the most prevalent populations associated with attachment trauma. According to Dorahy et al. (2015), populations with C-PTSD often display tremendous difficulty in affect regulation due to chronic dissociation, shame, and guilt. Further, disorganization of traumatic memories, flashbacks, and intrusive memories exacerbate the cognitive synapses of trauma victims (Jelinek et al., 2010).

Role of Attachment Trauma in Adult Relationships

As previously mentioned, attachment spans throughout life cycles. Bowlby's (1979) research revealed that attachment bonds developed in infancy transcended

throughout various developmental stages. Attachment bonds were identified to be a survival mechanism for species' progression and preservation. Bonding has practical purposes in this regard. In general, bonding promotes the movement toward familiar stimuli while simultaneously deterring the organism from unfamiliar sensation (Bowlby, 1979). This movement protects the organism from predators and maintains community, safety, and security.

Attachment bonds first develop in infancy and progress into adulthood. Secure infants become secure children who seek friendships and peer groups that are wholesome and nurturing; contrarily, children who are traumatized or have insecure attachment patterns develop friendships or relationships characterized by patterns of aggression, hostility, or delinquency (Suess et al., 1992). Children with disorganized or insecure attachment patterns may also develop problematic relationship patterns with their parents, such as controlling or caretaking behaviors, due to their disrupted attachment bonds (Riggs, 2010). These disrupted attachment bonds essentially establish the context for future relationships. Adult romantic relationships mirror parental relationships in four specific domain areas of attachment: establishing a secure base, maintaining proximity, creating a safe haven, and separation distress (Hazan & Zeifman, 1999). In addition, adult relationships include sexual components (Riggs, 2010).

Bowlby (1979) identified that when attachment is disrupted, the resulting psychopathological conditions substantially decrease the likelihood of secure pair bonding in adult relationships. Empirical evidence suggests that this is due to several factors such as disorganized self-concept, distrust in others, shame, fear or avoidance of

intimacy, and fear of rejection and abandonment (Crawford & Wright, 2007). Henry et al. (2011) reported that traumatic experiences such as combat trauma, adverse childhood experiences, and abuse decreased marital satisfaction in clinical couples due to the stressful effects of the trauma and the avoidant/anxious attachment tendencies associated with the experiences. Couples with trauma histories reported lower positive views of themselves and others which consequently impeded intimacy building, couple responsiveness, and engagement (Ruhlman et al., 2017). Attachment disruptions result in challenges with developing secure, intimate, and wholesome adult relationships.

Laddis (2019) provided extensive support for the understanding of the cognitive mechanisms that take place in victims of C-PTSD in the realm of relationships. From a psychological perspective, Laddis (2019) indicated that C-PTSD results from the substantial breach of caretaking relationships which causes complex levels of abandonment and betrayal to become characteristic in the victim's psyche. The fear of betrayal remains prominent for the victim as the victim navigates life cycles and relationship stages. This may cause the victim to behave in erratic ways, such as displaying a propensity for sabotaging behaviors, or requiring unrealistic expectations from partners to prove loyalty and affect. Laddis (2019) determined that because many of the experiences of the victim are inflicted in childhood, the victim develops a compromised sense of trust and intimacy. Intimacy is established in the parental capacity and if abuse or trauma is introduced, intimacy maps are distorted and severed. Thus, victims of C-PTSD suffer tremendous relationship distress due to their disordered belief system, experiences, and complicated internal working models. These flawed relationship

dynamics begin to emerge in early childhood and continue, if unresolved, remain prevalent throughout adult.

Attachment Trauma and Spiritual Relationships

Chronic experiences in trauma negatively impact spiritual relationships. Spiritual relationships are important to consider in the treatment of trauma because the distortion of spiritual relationships caused by trauma perpetuate symptoms of complex trauma (Ross, 2016). In fact, according to Ross (2016), spiritual beliefs about God or a higher power are often directly correlated to beliefs about oneself. Thus, if the trauma survivor believes that the higher power, deity, or entity did not protect the individual from trauma due to being unlovable, it is due to the unlovable nature of the person. Spiritual beliefs in C-PTSD victims are significantly more agitated than any other trauma group (Pressley & Spinazzola, 2015). This is due primarily in part to the intense feelings of shame, guilt, and sense of overall unworthiness that victims of C-PTSD carry. Because C-PTSD victims are susceptible to high levels of dissociative experiences, attachment in the spiritual capacity can also be severely compromised (Maltby & Hall, 2012).

It may be apparent that in the context of relationships, victims of C-PTSD struggle in the area of self-perception and affect regulation. Shame and guilt, specifically, impact the social and cognitive functioning of C-PTSD victims, especially in the domains of interpersonal and intrapsychic relationships (Dorahy et al., 2013). Individuals with chronic traumatization feel intense shame and guilt for what has happened to them and in most cases feel an overwhelming sense of responsibility for their abuse (Dorahy et al., 2013). This sense of shame and guilt transfers in the context of relationships, including

spiritual relationships. Many theorists believe that complex trauma is a disorder of memory, attachment and relationships (Proctor et al., 2019). This understanding presupposes that complex trauma transcends to a shattered conceptualization of all variations of relationships based upon a defective sense of self formulated from the past experiences of the victim. The victim applies the tenets of the conceived defective sense of self established precariously yet systematically through adverse exposure to every subsequent relationship the victim has throughout their lifespan. The first significant relationship is the parent-child relationship which is dyadic in nature (Muller, Sicoli, & Lemieux, 2000; Muller, Thornback, & Bedi, 2012; Proctor et al., 2019). The victim learns meaning and context from this dyadic relationship in childhood that becomes representative of all future relationships including the victim's spiritual relationship. The implicit knowledge gained from the traumatic experiences (e.g., I am not good enough; if God loved me then He would have saved me; I caused this abuse; I deserved this abuse; etc.) transfer to the victim's significant intimate relationships.

Development of Self-Concept

Bowlby (1969, 1980) described that the primary function of attachment was to establish and maintain proximity between caregiver and infant. When the infant is faced with separation, the infant becomes inconsolable and markedly distressed. This apparent distress is a signal of despair and grief that begins to formulate maladaptive cognitive schemas (Riggs, 2010). Distressful experiences in childhood, or adverse childhood experiences, are uniquely interconnected with a child's ability to attach securely. The child begins to create maladaptive narratives that are validated by negative experiences in

regards to self and others. Several risk factors also arise as a result of adverse childhood experiences. Adverse experiences in childhood lead to an understanding of a defective sense of self (Riggs, 2010). This defective sense of self develops into the individual's narrative of their self-esteem and concept.

Attachment Trauma and Impact on Self-Esteem

Traumatic experiences are significant risk factors in the development of core constructs for individuals. Specific domains of functioning such as social development, cognitive functioning, occupational, and esteem needs are most often impacted and shaped by experiences throughout the developmental years. For instance, Liu et al. (2018) found that childhood emotional abuse was positively correlated with fearful attachment and lower self-esteem. They discovered that people with emotional abuse reported lower global self-esteem, subjective well-being, and difficulty with attachment. Similarly, Lim et al. (2012) surmised that interpersonal trauma increased the risk of posttraumatic symptoms which posed significant implications for the internal working models of the individual, thereby impacting the individual's beliefs pertaining to self. Lim et al. (2012) found that PTSD symptoms were higher in interpersonal trauma populations due to compromised sense of self, preoccupied attachment, and decreased self-worth. Victims of interpersonal trauma blame themselves for the traumatic events, exacerbating their recovery.

Attachment trauma has debilitating effects upon the self-esteem of the individual. As the individual develops, they associate their trauma with their self-concept. Traumatic events lead to cognitive distortions, which can result in patterns of assimilated beliefs

(e.g., self-blame, minimizing, normalizing, undoing) or overgeneralizing beliefs (e.g., all people are bad, bad things happen to only bad people; therefore, I must be bad) (Iverson et al., 2015). Further, the severity of the attachment trauma and abuse causes psychopathological behavior, which diminishes social and cognitive skills as well as interpersonal relationships. These factors also mediate self-esteem (Brodski & Hutz, 2012).

Zetterqvist et al. (2018) explored the behavioral patterns of self-injurious adolescents exhibiting non-suicidal behavior and discovered that trauma symptoms were prevalent in these populations. They found that self-esteem and attachment was significantly lower in these groups. Adolescents who used sex as non-suicidal self-injury reported considerably low levels of self-esteem and low sexual self-esteem. Additionally, adolescents in these groups also reported high levels of adverse childhood experiences, significant detachment to self and high levels of self-blame (Zetterqvist et al., 2018). These findings are congruent with attachment theorists and research studies. Psychological abuse is one of the most deleterious types of abuse that can be inflicted on a person, resulting in severe cognitive distortions about self and others (Muller, Thornback, & Bedi, 2012). Childhood sexual trauma has also been found to be a significant mediating factor in the subjective well-being and global self-esteem of survivors, indicating that traumatic childhood experiences deeply alter the child's self-perception and overall well-being (Barnum, 2015).

Muller, Sicoli, and Lemieux (2000) stated that the IWM of the developing child were dyadic in nature; the IWM involved the interplay between the parent or caregiver

and the receiving child. Muller, Sicoli, and Lemieux (2000) also stated that the internal working models of the developing child were malleable yet generally remained relatively consistent over the span of time. Since attachment theory applies from birth to death, it would seem consistent that the implications of traumatic experience would also extend throughout the lifespan of the individual. Consequently, experiences influence the development of cognitive maps that influence pair bonding, romantic relationships, and interpersonal relationships, ultimately impacting esteem goals (Li & Zheng, 2014). Traumatic events help formulate cognitive schema responsible for faulty belief systems about self, others, and the world as a whole (Hyland et al., 2014; Weidl & Leuger-Schuster, 2018). Victims suffering from C-PTSD exhibit the higher levels of self-destructive thoughts and behaviors, faulty sense of belief, cognitive distortions, and intrusive thoughts among any other psychiatric population (Dyer et al., 2013; Cox et al., 2014).

Summary and Conclusions

C-PTSD causes significant psychological impairment and distress upon the victim. Empirical studies have indicated that victims of C-PTSD suffer intensely from intrusive cognitive symptoms manifested from the debilitating effects of developmental trauma (Dorahy et al., 2013; Dorahy et al., 2015., Dyer et al., 2013). Developmental trauma, or attachment trauma, fundamentally alters the psychological experience of the individual and contributes to a distortion of the individual's psychological self. This distortion impacts several domain areas of function such as cognition, social skills, relationships, interpersonal dynamics, and overall quality of life.

Many studies have explored the role of attachment trauma in the manifestation, prevalence and impact of numerous psychiatric disorders, including C-PTSD (Beeney et al., 2015; Lysaker et al., 2011; Rokita et al., 2018). These studies have provided substantial evidence indicating that traumatic experiences can cause significant neurological damage that can impede developmental processes necessary for psychological functioning. Additionally, traumatic experiences have also been determined to be responsible for suicidality among a high number of patients with depression, anxiety and other mood-related disorders. Empirical research provides evidence that attachment trauma has a clear connection between the development of psychiatric disorders and the exacerbation of symptoms.

Attachment trauma also impacts the progress of healthy relationships in many instances. Studies have shown that individuals with histories of traumatic experiences, complex or otherwise, often report significant complications developing intimate and fulfilling relationships (Henry et al., 2011; Laddis, 2019). The breadth of research concerning of C-PTSD and attachment trauma provide a preliminary understanding concerning the devastating nature of C-PTSD. Chapter 3 discusses the research design and rationale, the role of the researcher, research methodology, and relevant issues of trustworthiness.

Chapter 3: Research Method

Introduction

The purpose of this study was to evaluate the fundamental role of attachment trauma in the development of self-concept of C-PTSD victims. There is increasing support that indicates attachment trauma plays significant roles in the development of many mental health issues and dispositions (van der Hart, 2018). There is also evidence that attachment trauma contributes to the formation of sense of self (Bowlby, 1969). However, there is a gap in the research concerning the decisive role of attachment trauma in the development of self-concept for victims of C-PTSD.

In this chapter, I present the research design and rationale for the design. I further explain the role of the researcher as it pertains to the specific chosen design. Methodology is presented in significant detail, exploring participant selection process and logic, instrumentation, data collection methods, recruitment methods, and data analysis plan. Issues of trustworthiness and ethical procedures is also discussed along with proper application procedures for institutional review board (IRB) approval.

Research Design and Rationale

Research Questions

Central Research Question: What are the lived experiences of C-PTSD victims?

Subquestion: How does attachment trauma shape the C-PTSD victim's self-concept?

Research Design

The design chosen for this study was an interpretive phenomenological analysis, a qualitative approach, to evaluate the relationship between attachment trauma and the self-concept of victims of C-PTSD. Phenomenology is the study of an experience, event or phenomenon that has happened to an individual or group of people (Burkholder et al., 2016). A phenomenological account is not something that can necessarily be quantified but is something that is sought to be understood as an experience in the context of reaction, response or perception. Thus, when researchers are attempting to understand an experience, perception or the impact of experiences on individuals, phenomenological analyses are most often used to ascertain results (Burkholder et al., 2016).

In phenomenological studies, researchers seek to understand a particular phenomenon by first understanding the individuals' narratives of the particular phenomenon (Eatough & Shaw, 2017). Researchers develop an understanding of the phenomenon by comparing shared experiences within the narratives of the participants in the study by explicating their descriptions, themes, and concepts. In interpretive phenomenological analysis, the researchers search for psychological and sociological factors that may have contributed to the responses of the participants (Burkholder et al., 2016). These findings help establish an understanding concerning the implication of the phenomenon and how people respond to that specific phenomenon in similar environmental circumstances. Because phenomenological studies aim to study depth, quantity is not recommended (Burkholder et al., 2016). Sample sizes are recommended between 10 to 15, with most studies averaging around 12 participants (Burkholder et al.,

2016). Additionally, researchers often spend considerable time with participants, interviewing them several times in the duration of the study to ensure adequate data collection.

There were other qualitative approaches that I could have used for this study. For instance, a grounded theory approach would have been a good alternative that could answer these research questions to some degree. However, in a grounded theory approach, the research design would be focused on understanding the meaning of the experience and perhaps the role of change, conditions, and actions (Burkholder et al., 2016). Thus, using a grounded theory approach would fail to address the research questions on how attachment trauma shapes the development of self-concept. In this regard, using a phenomenological approach as best suited for this study.

Rationale for Study

The rationale for using a phenomenological approach for this study was that the aim of this study was essentially concerned with exploring a phenomenological account. The lived experiences of C-PTSD victims provided a detailed narrative that illustrated the impact that attachment trauma had on the development of their self-concept. A quantitative approach would most likely indicate a correlational relationship (Burkholder et al., 2016). It would fail to address the specific way that attachment trauma truly shapes the perception of the victims of C-PTSD. Since this study was focused on perception, it was not focused on the need to quantify the experience, prove the validity of the experiences, or determine if the experiences needed to be investigated (Ivey & Myers, 2008).

Role of the Researcher

My role of the researcher in this study was that of an observer. This meant that I did not participate in the study in the context of supplying data, influencing the participants' responses, or in any imposing biases that led indirectly or directly to impact the integrity of the results (see Burkholder et al., 2016). It was imperative that I was mindful of my biases to avoid any kind of interplay of perception that could have influenced participant responses.

My main function as the researcher was to collect the data and synthesize it in a manner that could be analyzed, understood, and thematically concluded. This required considerable attention to my responsibility in maintaining the utmost fidelity in recording responses without influencing participants, indicating to participants that they were answering to prove hypotheses, sharing researcher's own experiences, or data from other participants (see Burkholder et al., 2016). I was also responsible for understanding implicit biases through a process known as bracketing in which I conducted a thorough understanding of my own experiences to avoid countertransference of personal experiences into the data analysis process (see Burkholder et al., 2016). I was intentional in collecting accurate data; therefore, I recorded interview responses to ensure accurate coding was enabled. Bracketing also ensures that researcher bias does not influence data collection. Proper training of any persons who are involved in the data collection process is integral to ensure for the integrity of the results (Burkholder et al., 2016).

Methodology

Research studies require specific steps in order to be ethical, viable, and dependable (Burkholder et al., 2016). I discuss in the following section the proper steps that were taken pertaining to the selection of participants, data collection, data analysis, and instrumentation. Additionally, I address issues of trustworthiness and ethical concerns.

Participant Selection Logic

The population I selected for this study comprised of nine participants who met the diagnostic criteria of complex posttraumatic stress syndrome. The sample size was smaller since this was a qualitative study and sample size was focused on depth of information (Burkholder et al., 2016). Participants were selected from a counseling center that specializes in the treatment of patients with a diagnosis of C-PTSD.

Participants were selected if they met the diagnostic criteria of C-PTSD, were in stable mental health condition for a period of a year, and had been in therapy for at least 2 years. This information was ascertained by completing the eligibility criteria form (Appendix A). I emailed participants consent forms with IRB approval and provide a detail of the requirements of the study. I provided study details in the informed consent and a returned emailed questionnaire served as consent to participate in the study. Participants who elected to participate received a $10 Visa gift card via secure email upon completion.

Instrumentation

The instrument I used for my study was self-report questionnaire comprised of 12 questions that I developed. According to Truijens et al. (2021), self-report questionnaires are the gold standard in qualitative analysis for obtaining accurate findings. I chose to develop my own questionnaire because there were not any questionnaires I could find that could adequately measure the relationship between attachment and self-esteem that I was attempting to determine (see Truijens et al., 2021). Since this study was focused on exploring a specific gap in literature using a phenomenological study, it was reasonable to use a self-report questionnaire that allowed participants to freely provide details pertaining to their lived experiences (see Truijens et al., 2021).

Procedures For Recruitment, Participation, and Data Collection

Participants were recruited from a trauma facility that serves patients with a clinical diagnosis of C-PTSD. The clinical director provided permission for me to use the site to conduct this study and allow the recruitment of participants from the facility. I collected the data through email format and followed up with participants on a weekly basis to ensure participation. To encourage participation, I incentivized responses with a redeemable $10 gift card upon completion of the questionnaire.

The participants were given all information regarding consent, confidentiality, and anonymity pertaining to the study and were also debriefed upon completion of the questionnaire. Participants were provided with information that was relevant to them in the event of activation of symptoms of distress caused by questions in the study and how to seek help. Since the questionnaires were completed electronically, there was no

requirement for reporting to a facility or site. Therefore, participants completed the questionnaire at their convenience and at their pace.

Data Analysis Plan

There were several data analysis methods that were utilized in coding and indexing the results of the self-report questionnaires. The most appropriate method that had fit this particular study would be the grounded theory method, which required comparison between the questionnaire reports for similarities and differences with particular interest to the theoretical underpinnings of the study (Clark & Braun, 2017). This allowed proper coding methods between participant responses.

Bracketing, which was another technique that is useful in data collection, was also needed to be implemented during this process (Chan et al., 2013). Bracketing is the process of intentionally putting aside the researcher's biases, preconceived notions and presuppositions so that the study can be conducted without prejudice. This was an imperative step in the process to ensure that the study was valid and reliable.

Issues of Trustworthiness

In the process of conducting a qualitative study, there were several issues of trustworthiness that needed to be addressed to provide a reliable and valid study. Qualitative studies essentially bear the responsibility of proving that they can be trusted. This tremendous task was proven through a series of steps that the researcher took in establishing credibility, transferability, dependability, reliability, and confirmability (Kortsjens & Moser, 2018).

Credibility was established by utilizing prolonged engagement in which participants were tested for misinformation, familiarized with the setting, and rapport building. By enlisting the support of the staff members of the facility, the participants were able to establish rapport with the researcher and the researcher was in a better position to ascertain misinformation, data enrichment, and familiarity with setting. Additionally, member checks were another technique that were utilized to establish credibility. Member checks required the responses to be sent back to the participants to ensure accuracy in recording. This also allowed the opportunity for both respondents and the researcher to evaluate the data to determine that information is concise.

Transferability was established by utilizing thick description as a technique to conceptualize both the experiences of the participants as well as the context in which the experiences pertain. In essence, a thick description allows subsequent readers of the research to determine if the setting of the research can apply to their own personal setting based upon the description (Kortsjens & Moser, 2018). Additionally, audit trails served as a useful method to establish dependability in qualitative research. The researcher kept a record of steps taken from the origination of the research to the completion of the research. Furthermore, the researcher was responsible for providing the appropriate and necessary steps that were taken to demonstrate findings so that the study could be duplicated for future studies (Kortsjens & Moser, 2018).

Confirmability differed from dependability because it was the researcher's intentional effort to remain unbiased. Reflexivity was a useful technique to establish confirmability because it allowed the researcher to demonstrate objectivity in the study.

Objectivity could be validated through the use of diaries in which the researcher documented implicit and explicit biases, preconceived notions and presuppositions, and how these ideologies may have affected the study (Kortsjens & Moser, 2018).

Ethical Procedures

The process of conducting a study involving human participants requires permissions and approval from the Institutional Review Board. The Institutional Review Board is responsible for ensuring that all research that is completed complies with the ethical standards and regulations of Walden University as well as federal United States regulatory ethical practices. Prior to conducting the study, the researcher had to obtain approval from Walden's Institutional Review Board. This approval was received on January 25, 2022. The IRB approval number was 01-25-22-0572515.

Informed consent was another ethical process that needed to be addressed. Studies cannot be conducted without proper consent. Informed consent requires proper information pertaining to the study, the purpose of the study, any potential for risk or harm, information regarding potential benefits to society or participants, any monetary gain or compensation, sample questions for study, information regarding confidentiality. Additionally, information regarding debriefing was included, which entailed the process of contacting participants' providers at the site in the event of emotional activation due to questions pertaining to the study. Providers at the site were available for support throughout the study to avoid harm to participants.

Another possible ethical concern was the potential for participants withdrawing from the study or refusal to participate in the study. To minimize the possibility of early

withdrawal, the researcher is incentivizing participation with a gift card of $10 that was delivered upon completion of participation. In the event of refusal to participate in the study, the researcher had planned to coordinate with dissertation chair to obtain participation from Walden University student body for participants.

Participant data was kept confidential and anonymous. Information was secured and stored in a HIPAA-compliant email software for the course of this dissertation study. The researcher and the researcher's dissertation committee members had access to the data material and the material is securely maintained for 5 years to comply with IRB.

Summary

This chapter explored the process of conducting the research for this study. The purpose of this study was to evaluate the role of attachment trauma in the development of self-concept in victims of C-PTSD. This was a phenomenological study that utilized a researcher-developed instrument to assess the participants' results. Additionally, this chapter provided an in-depth explanation of the participants who were selected for the study, and how to address issues of trustworthiness. Chapter 4 explores the setting, demographics, data collection, and results of the study concerning the role of attachment trauma in the formation of self-concept in victims of C-PTSD.

Chapter 4: Results

Introduction

The purpose of this study was to assess the role of attachment trauma in the development and formation of the C-PTSD victim's self-concept. There is substantial limitation in the mental health industry concerning any correlation between attachment trauma and self-concept concerning C-PTSD populations. The study was an interpretative phenomenological study and all data collected served to answer two main questions: What are the lived experiences of C-PTSD victims and how does attachment trauma shape the self-concept of the C-PTSD victim?

This chapter provides the data collection methods that were used in the study, which includes the number of participants, data analysis techniques, and instrumentation. In this chapter, I further explore the relationship between the data through the use of thematic coding to provide a comprehensive analysis of relevant themes, ideas, and concepts. The findings of this study were reviewed and scrutinized through the context of credibility, trustworthiness, transferability, and confirmability, as discussed in the previous chapter. Additionally, I explore concepts or ideas that emerged through the course of the study that bring new insights to this topic.

Setting

Participants received recruitment flyers from a mental health provider with my contact information. I received emails from interested participants and emailed the eligibility criteria form, informed consent, invitation to participate form, and interview questions. Participants were given 14 calendar days to respond to the interview questions.

The informed consent form indicated the confidential nature of the study as well as the potential risks associated with this study. The consent form also recommended appropriate protocol in the event of being triggered due to stress incurred from the study. The IRB approval for the consent was 01-25-22-0572515 and this approval was set to expire on January 24, 2023. The emailed response to the questionnaire served as consent to participate in the study. Upon completion of the study, the participants were emailed a secure link to an electronic $10 Visa Gift card for their participation. Eleven participants responded via email indicating an interest in participating; a total of nine submitted responses to the interview questions via email and completed the study.

Demographics

All participants of this study were adults ranging between the ages of 18-65 and had a clinical diagnosis of C-PTSD. They were in therapy for a minimum of 2 years and reported to have stable mental health conditions. Stable mental health conditions denoted the following: no episodes of psychosis, self-harm, suicidal ideation, manic episodes, or homicidal ideation within the last year. Additionally, participants reported to be in the maintenance phase of therapy. Additional demographic information was not relevant to this study and was therefore not recorded or collected.

Data Collection

Upon receipt of participant responses to the interview questions, I imported data to NVivo, a qualitative analysis software. There were no unusual circumstances that were noted during the data collection process. Data was recorded as Participant 1, Participant 2, Participant 3, Participant 4, Participant 5, Participant 6, Participant 7, Participant 8, and

Participant 9 to maintain confidentiality of respondents. The only identifying information obtained during the course of this study was the respondents' email addresses. The emails have been purged from the computer system and questionnaires are retained for a mandatory period of 5 years to maintain compliance with IRB guidelines. There were also no variations in data noted during collection. All participants met eligibility criteria and saturation of data was met at five participants; however, I continued data collection for an additional four participants to ensure accurate results.

Data Analysis

The instrument that I used for this study was an interview questionnaire that I created (Appendix B). The first two questions in the questionnaire asked the participant to evaluate the relationship they had with their caregivers and if participants felt that caregivers provided for their emotional needs. Question 3 asked participants how they viewed themselves growing up. The fourth question explored participants' ability to handle tasks and challenges. The fifth question evaluated levels of doubt and insecurity. The sixth question asked how participants view themselves presently. The seventh question asked participants to explore the quality of their attachment relationship with their caregivers. Questions 8 and 9 explored positive and negative cognitive schemas. Question 10 explored areas of self-doubt as an adult. Finally, Question 11 evaluated cognitive symptoms of distress in the present and the final question explored ways participants' attempt to maintain a positive mindset.

The process of synthesizing and analyzing data was conducted using interpretive phenomenological analysis (IPA). IPA combines elements of phenomenology,

ideography, and hermeneutics to provide descriptive analysis and interpretation of how aspects of life are experienced (Pietkiewicz & Smith, 2012). Phenomenology is the understanding of experiences; ideography explores details of accounts and hermeneutics is theory of interpretation (Charlick et al., 2016). From a research perspective, IPA seeks to explore experiences through the participants' accounts, removing researcher bias, integrating interpretation and context, and detail (Charlick et al., 2016). The process of data analysis using IPA methodology consists of six steps as outlined in Figure 1 (Smith et al., 2009).

Table 1

IPA Methodology

Step 1	Reading and re-reading data: Immersion in the data, checking transcripts and data sources for accuracy, keeping participant orbital throughout process.
Step 2	Initial note-taking: Documenting metaphors, paying close attention to semantics, contextual language, observations
Step 3	Emergent themes noted: Begin analyzing data to formulate themes
Step 4	Search for connections across emergent themes: Find connections or commonalities
Step 5	Repeat process by moving to next case
Step 6	Look for patterns across all participants: convergence and divergence of themes

The answers to each question were read several times to ensure accurate understanding of responses. Each sentence was dissected using an inductive method of analysis to identify emergent themes. I documented phrases and statements that outlined

participants' experiences. The process of documentation led to the formulation of emergent themes. There were four prevalent themes. The first theme that emerged was adverse childhood experiences. The second theme that emerged was emotional dysregulation. The theme of meta-cognitive and task-related skills also appeared. Finally, the theme of resilience was apparent through data-analysis.

These themes are further discussed in the results. Relevant subthemes also emerged. There were eight total subthemes with significant results. These were (a) caregiver limitations, (b) traumatic attachments, (c) cognitive distortions, (d) emotional and safety needs, (e) distress symptoms, (f) negative self-concept, (g) self-regulation skills, and (h) positive attachments. Following the discovery of themes and subthemes, I analyzed responses to determine if there were any convergence or divergence across the themes. Detailed audits of the responses indicated that themes and subthemes were consistent across the participants' responses.

Evidence of Trustworthiness

Qualitative research requires levels of trustworthiness to be established in order for the results to be reliable. Credibility for this study was established by providing the participants safety in their own setting, access to their own mental health provider in case participants felt triggers due to stress, and complete disclosure of study details. Moreover, there was no physical interaction between participants and me, which ensured that the responses were unprompted. Also, participants received the interview questions once they met the eligibility criteria. This ensured that participants consented to the participation, met the diagnostic criteria, and understood the nature of the study.

I did not alter any responses to questions at any time during the course of this study. This ensured dependability of the study. Additionally, I did not impose any implicit biases, thoughts, preconceived notions or opinions into the analysis, safeguarding confirmability. The interview questions sought to understand the experiences of the participants in order to expound upon the understanding of attachment trauma. I implemented thick description in the results section so that transferability of results was evident. I refrained from internalization of results and manipulation or alteration of information to maintain integrity of results. Finally, I used a qualitative software program to guarantee that results were accurate and unbiased in an additional effort to increase trustworthiness.

Results

The goal of this research study was to understand the role of attachment trauma in the development of the C-PTSD victim's self-concept. Nine participants responded to emailed interview questionnaires after meeting eligibility criteria. There were 12 questions on the researcher-generated questionnaire (Appendix B) which was used to answer two research questions: (a) What are the lived experiences of C-PTSD victims? (b) How does attachment trauma shape the C-PTSD victim's self-concept? The results of this study contain several codes and subsequent themes.

Theme 1: Adverse Childhood Experiences

The theme of adverse childhood experiences resulted from the culmination of subthemes of caregiver limitations, traumatic attachments, and cognitive distortions. All nine of the participants indicated aspects of their childhood that alluded to some form of

caregiver limitation and traumatic form of attachment, as well as significant distortions in cognitive schemas. All nine participants reported several ranges of experiences in their formative years that were saturated with adversity. Six participants shared instances of sexual abuse during their early childhood years by their caregivers. Seven of these participants were also physically abused and neglected. Participant 4 recalled concerns about food and safety. There were instances of parentification. Participant 4 also indicated, "I remember being the one who would stand up to him during his rages to protect my mother." Participant 7 reported, "I was beaten, terrified, abused, and raped in my home." These experiences of adversity were prevalent throughout the participants' childhoods, impacting several aspects of their development.

Verbal abuse and ridicule also impacted some of the participants. Participant 8 indicated, "When I made choices that she didn't approve of she would call me stupid or tell me I was making bad decisions." Participant 3 shared, "She was incredibly critical as well, we had to do almost all of the chores and would get yelled at if she felt we didn't do a good enough job." Participant 7 reported, "I was beaten, terrified, abused and raped in my home." In describing the relationship with caregivers, Participant 3 shared,

> My parents were fighting almost constantly while he lived at home. He was in some ways the warmer parent, he would sometimes take us to the park, etc. He also was a pedophile, so most of the positive attention I got from either of my parents was while I was being sexually abused by my father. My mom knew he was a pedophile before I was born, she walked in on him molesting my sister when she was pregnant with me. We were raised in a religion (Seventh-Day

> Adventist) that expressly forbids divorce, except in the case of adultery. Dad would threaten and intimidate mom, I witnessed sexual violence against her as well.

Participants shared that the verbal assaults from their caregivers were constant, repetitive and unrelenting.

Adversity also displayed itself in ways such as avoidance toward the participants. For instance, Participant 5 reported that their maternal caregiver was usually ambivalent toward them, creating a sense of confusion for the participant. Participant 5 indicated,

> We had been asking for help for our mental health since we were 3, but mum kept insisting that we were fine and every emotional pain was us just being ungrateful and selfish. She could be really cold and judgmental and we never felt like good enough for her. She wouldn't let us touch her much and sometimes reacted disgusted to us wanting to cuddle. We see her kinda like a cat, she can be very friendly and cuddly, but only on her terms and if you're not careful she'll claw you.

Additional examples of participants' statements regarding adverse childhood experiences are shown in Table 2.

Table 2

Adverse Childhood Experiences

Participants	Statements Regarding Adverse Childhood Experiences
Participant 1	"We had endured a lot of abuse prior to the move, but part of me was still crushed to leave my dad. Once we left the violent home life, I had a very rocky relationship with my mom."
Participant 3	"I saw my father on occasion, he continued to sexually abuse me even after he left home. At some point, there was a court order that my dad could only see us when supervised by a social worker, and the sexual abuse stopped after that."
Participant 4	"He would physically hit us with the belt from his pants and my mother walked away or ignored it."
Participant 5	"He could be very sadistic and would often hurt us for fun."
Participant 7	"He walked out of my life when I was a very young age and just became a voice on the other end of the phone."
Participant 9	"The only time he truly engaged with either my sister or I was to yell at us."

Subtheme One: Caregiver Limitation

All of the participants indicated significant caregiver limitations which resulted in poor emotional attachment and development of emotional security. Participants reported assortments of limitations for their caregivers from mental illness to substance use disorders to criminal histories. Caregivers lacked the capacity to parent these respondents as indicated by the responses. All nine participants specified several aspects of trauma pertaining to caregivers. Participant 3 reported that "Mom seemed either completely

numb and dissociated, or would fly into a rage." Participant 6 stated that caregivers were "very toxic, both are text book addicts." Participant 1 wrote,

> She worked all the time and never truly understood how to deal with the emotion turmoil I was feeling. She used me as emotional support and after a while I became similar to a husband to her. I heard about her work day and the drama at the office, I heard about all the money issues or stress she was feeling raising us. I was no longer her child, we were peers. My teenage years were terrible and I rarely wanted anything to do with my mom and I wanted nothing to do with my dad.

Instability permeated through these caregivers, creating an environment of turbulence for the participants.

The findings of this study indicated that caregivers did not attend to their children's emotional needs. There was a significant gap between the actual need of the participants and what they inevitably received. For instance, Participant 7 shared a detailed incident of a time when they were excessively disciplined at school in their formative years by their caregiver. Participant 7 reported,

> I become talkative and a class clown, even on my report cards it would say talkative in the little note boxes, but I felt like I was starting to belong. Not really but enough. My mother brought that crashing down though, when she started coming to the school mid first grade, when I got in trouble and beating me in the bathroom. There was no door on the bathroom, so it echoed down the hallway. It took me forever to leave down the embarrassment and shame and the names and

> the kids picking. It stopped by second grade, because by then I started looking like the tiger on the Thunder cats and the school threatened to call DSS.

Some caregivers were extremely cruel in their interactions with participants and the other household members. Six participants discussed instances of discord between caregivers, creating environmental strain for the participants. Respondents recalled significant emotional turmoil, distress and difficulties regarding their sense of self and safety due to these conflicts. Participant 4 shared,

> When he would go into his rages, he would withhold money from my mother as a way to punish her. I often remember not having enough food in the house. When I was in high school, he refused to pay the private school tuition for me and my sisters as a way to take it out on my mother. I remember being so upset and worried if he would pay it. My grandmother had to pay our tuition for about 6 months. When he was angry about the telephone bill, he shut off the phone. He was more than able to provide for my basic needs. He had a good job and money was not the issue. He was very spiteful and tried to punish my mother by withholding money etc.

Another example of caregiver limitations was expressed by Participant 3, who indicated that even divorce did not relieve the exacerbated circumstances at home. Participant 3 shared that when their father exited the residence due to the divorce, the father was violent and abusive. Additionally, Participant 3's mother did not provide any mental reprieve. Participant 3 noted,

> She would put down our hobbies and interests, she told us that no one liked us or wanted to be around us. She wouldn't usually allow us to spend time with other families or with other kids outside of school. She would blame us for her own financial decisions, saying it was our fault that we were struggling financially. I tried my best to just avoid her as much as I can and do well in school so I could be independent and that ended up working out well for me. I started performing so well in school that it fed into her own ego and how she presented herself to the world and that offered me a bit more safety as well.

Table 3 includes some additional statements from participants regarding caregiver limitations.

Table 3

Caregiver Limitations

Participants	Statements regarding Caregiver Limitations
Participant 3	"She would often intentionally antagonize us, then yell at us even more for being upset by it."
Participant 4	"He was extremely critical and condescending."
Participant 8	"It was almost like she was 2 different people."
Participant 9	"My dad has the habit of giving his unsolicited opinion which tends to feed my self-doubt."

Subtheme Two: Traumatic Attachments

Participants surmised that their attachments to their caregivers were very unstable and unhealthy. Responses to questions indicated that participants did not experience

secure attachments to their primary caregivers and did not feel as though their caregivers responded to their attachment needs. Three participants reported that they felt the need to protect their caregivers and assumed the role of a parent to compromised caregivers. For instance, Participant 4 shared, “My relationship with my mother was one of protector, I felt that I was the adult, and not the child.” Participant 4 listed,

> I remember when my father hit my mother, and she was bleeding all over her face. I screamed and was crying and ran to hide in my bedroom closet. I never remember my mother coming to see if I was ok. She didn't try to talk to me about it. I didn't feel like my mother protected me. But I had a strong need to protect her and I took on that role. When I was a young adult, my mother was hospitalized and very sick. I remember feeling so worried and fearful that she was going to die. When she shared that her blood results improved, I started to cry tears of joy and expressed how relieved and happy I was. I will never forget how she made me feel that day. She told me to stop and said that I was acting ridiculously. Her negative response to my crying and true concern for her made me feel foolish and that my feelings didn't matter. The message I received was that there was something wrong with me.

Similarly, Participant 2 indicated that they had a parentified role toward their primary caregiver which resulted in significant stress and attachment difficulties. Participant 2 reported that their biological parents were divorced and their mother would confide in the participant inappropriately, causing the participant to feel emotionally responsible for their mother. Participant 2 shared,

> My mother viewed me as an extension of herself and held me responsible for her feelings and reactions. There were many times, as a child, I had to console my mother and stepfather during conflict and help resolve things. My mother vented to me about her childhood abuse and her savage rape; my first memory of this I was 12/13 years old. I wanted to depend on my mother but did not feel safe doing so. My relationship with my stepfather was shallow and superficial, and honestly still is. The parent I feel closest with is my mother. Our relationship has improved immensely and we have a healthy secure attachment, now. My stepfather was more reserved and his OCD and personal traumas kept him from being vulnerable with me and really connecting. The only time I felt like he paid attention to me, was when I was being punished or lectured for hours.

Participant 7 shared similar sentiments regarding their attachment relationship toward their primary caregivers. Participant 7 recounted that they knew their father through abstentia, which created a pattern of thoughts concerning the participant's self-worth. Participant 7 also reported,

> My relationship with my mother, was the exact opposite, I went from being nothing to her, to her everything. Her reason for hating her life, her reason for financial struggles, her embarrassment, her whipping post, her burden to carry, her regret and her reason for not wanting to live any more, etc. At her best she was distant, just a picture of a laughing individual standing in a crowd on television, ignorant of me and my needs. My tolerated existence and caring moments far and few between, completely dependent on her moods. At her worse,

> I was this thing that she hated, this frustrating thing that refused to die. This thing that needed to be drowned, beaten, terrified, ignored, criticized that on rare occasion provided her some pride in front of others. She was not all bad, there were some good moments, moments where I thought "she does love me." This made her return to hating more and more painful each time.

Some reported feeling forsaken and neglected. An example of this was shared by Participant 3 who wrote, "I felt abandoned by my dad." Findings from this study indicated that attachment styles communicated meaning to participants. For instance, Participant 1 shared that their attachment toward their caregivers relayed distorted belief systems and a defective sense-of self. Participant 1 indicated,

> My dad was in and out of prison and was always cheating on my mom. He went out every night or most nights after work and sometimes didn't come home. But it wasn't secure in the sense that I always felt like I had to have a reason for existing or they wouldn't love me. I was well aware from a young age how much of a pain in the ass I was as an infant and everyone told those stories to be funny, but I heard them as insults and that there was something wrong with me. I was unwanted and there was something inherently wrong with me.

Table 4 identified some of the statements participants made regarding their attachments toward caregivers.

Table 1

Traumatic Attachments

Participants	Statements Regarding Traumatic Attachments
Participant 6	"There was no quality to the attachment. I loved them and was grateful they took us in, but wish I was given to a different family."
Participant 7	"The relationships with anyone perceived as a caregiver, swings between anxious-ambivalent, and avoidant"
Participant 8	"Today I would say have a detached attachment. I love my mom, but I have to love her from a distance."
Participant 9	"I see my attachments as seams and each seam is slowly unraveling."

Subtheme Three: Cognitive Distortions

Respondents shared several cognitive distortions that were documented separately to provide further understanding concerning the impact that attachment trauma rendered on the psyche of these participants. For instance, Participant 1 reported that their "attachment was based on what I could do, how well I could be liked and how I could be of use." Participant 1 wrote that "I did my best to be a good girl and not get in the way" and that "I am unwanted and unlovable." Participant 2 indicated, "I did not believe that I was really loved and felt I had to earn love by being perfect, and people pleasing, and being who my parents wanted me to be." Some shared their self-worth was based on the perception and approval of others. Participant 7 wrote, "My mother created in me a child that would never leave her, that would stick to her to the point of her own death to give her what she needed."

The resounding cognitions of participants was unloved, unworthy, helpless, weak and defective. These distortions were prevalent among the participants and stemmed from the attachments from their caregivers. Participants echoed the same concerns and questions, wondering what they did wrong to deserve their caregivers' responses and what they could have done better. Participant 7 reported,

> The negative beliefs I have about myself I that I am pathetic, weak, and that I am so dysfunctional that the only man I am capable of feeling connected to is my abuser or someone who is abusive. I believe that I am kidding myself in pursuing these goals that I have laid before me and that it is pointless because I will never have anyone to share it with and that I miss my fantasy life. I believe that I am fat and disgusting and ugly.

Participant 2 reported similar distortions in cognition pertaining to self. This participant indicated that these invasive thoughts have been consistent and pervasive throughout their childhood and even into their adulthood. They stated,

> I still have negative beliefs about myself. These feelings are not constant, as they once were, but arise when it is in an activated state or when I am in a depressive episode. These beliefs are the following: that I am a burden, I deserve to be punished, I am nothing, I should disappear, no one really loves me, I am ugly and no one should touch me, that no one cares about what I have to say or what I feel, that people are using me, that people lie, I can only trust myself, I can only depend on myself, people only hurt me, I don't deserve to eat, I am a waste of space and air.

Table 5 illustrated some statements pertaining to participants' cognitive distortions.

Table 2

Cognitive Distortions

Participants	Statements Regarding Cognitive Distortions
Participant 1	"I feel like I deserved the bad things that happened to me."
Participant 2	"I doubt that others care about my existence and at times feel that everyone would be better if I didn't exist."
Participant 4	"I often felt like I was stupid and couldn't do it."
Participant 5	"That we're weak and only burden others"
Participant 6	"I am unworthy of love."
Participant 9	"I doubted that the people around me cared enough value my opinion"

Theme 2: Emotional Dysregulation

The theme of emotional dysregulation arose from distress symptoms and emotional and safety needs. Participants reported several instances of substantial challenges in regulating their emotions. All nine participants indicated that they often struggled with feelings of being overwhelmed and would suppress emotions. Negative emotions and experiences would be internalized as part of the participant's self-concept, thus contributing to the cycle of dysregulation and cognitive distortions. Participants reported ranges of dysregulated behaviors throughout the course of their childhoods. Some reported eating disorders, self-harming tendencies, suicidal ideation and attempts, sadistic urges and fantasies, dissociative symptoms, and loss of control. For instance, Participant 9 recalled,

My struggle depends on what has or is happening around me. I feed off my surroundings. When I am alone in an unfamiliar setting is when I struggle the most. I am relying on solely on my own senses and preparation for what could happen, I easily become overwhelmed with all the sensory input and trying to decipher what's going on in addition to the meaning of what I've perceived of those around me. My difficulty increases with interactions. When I am in a familiar place it is easier to handle just the information of those in the space rather than making a mental map of what's around me while also surveying the people. When I am with my service dog in training or someone that is aware of my troubles, there's less input I'm responsible for…At the point I am completely and totally overwhelmed I tend to panic and then dissociate. I don't know how to manage everything going on around me and I become afraid of those around me, if they'll touch me, speak to me, or any other number of things that goings through a person's mind when they see me freeze, stop in motion, flinch away from someone that is standing to close or speaking too loudly. These thoughts make the panic worse until I've inconsolable and dissociate so that what happens next, or my reactions are forgotten and aren't a source for further trauma. Dissociate leads to episodes of depression because I am unable to recall hours of time and feel unaccomplished for how much I've slept or all I remember is that I've slept. If I am isolated then there is less, just less. If I am a more active participant of society, there is more.

Five participants reported self-harming tendencies and suicidal ideation. Participant 2 reported that “my addiction to self-harm which followed me into adulthood.” Participant 5 reported that they experienced cognitive distortions that propelled emotional distress to the point of fueling the desire to end their own life. They shared,

> Mostly we were too dissociative to think clearly. I remember that some of us spent most of our life obsessing over us being fundamentally bad and evil. We developed sadistic fantasies and urges, probably mix of predisposition and suppressed anger. So, some of the alters who were invested in us being "good" were desperate about us having urges to hurt others. We tried killing ourselves unsuccessfully again, because some of us were scared that we'd eventually be unable to contain the urges and kill someone.

Table 6 depicts some statements from participants regarding their struggles with emotional dysregulation.

Table 3

Emotional Dysregulation

Participants	Statements Regarding Emotional Dysregulation
Participant 1	"Leave me feeling out of control and overwhelmed."
Participant 2	"Internalized my emotions and opinions and, in my teens, started to get very depressed and self-harm regularly."
Participant 3	"I would also get dysregulated around other people a lot."
Participant 7	"Guilt, disgust, self-loathing and self-destructive behaviors"
Participant 9	"I flee because it's easier that continually being let down and left behind."

Subtheme Four: Emotional and Safety Needs

All of the participants indicated that their primary caregivers failed to meet their essential emotional and safety needs. For instance, most of the participants indicated that their caregivers were erratic in providing for their emotional needs during their childhood. Participant 3 wrote,

> Both parents were abusive and neither protected us from the other. The places I would go to escape mom (my room, the basement) were places that my father had abused me, so I didn't really have anywhere at home that felt very safe. My mom did fight legally for the court order to have a social worker present when visiting dad, which offered some safety at some point.

Another respondent reported that they felt neglected during their entire childhood. Some participants reported that caregivers would not allow expressions of emotions, such

as fear, worry, or sadness. Others reported that they never felt comforted or soothed by their caregivers. Participant 9 reported

> My dad is the one who would repeatedly tell me to always keep my head on a swivel. I wasn't exactly permitted to feel many negative emotions. If I were to cry for any reason, I was yelled at; if I yelled or showed anger, I was yelled at; if I overshowed my excited, I was scolded; any emotion that altered a passive state was unacceptable. Even if my displayed emotions were justified, for example pain, I was called dramatic and told to suck it up. I feel that my parents did not provide at all for my emotional needs.

Participants indicated high levels of emotional distress. They reported increased anxiety, hypervigilance, nervousness, panic, and fear. For instance, Participant 4 indicated,

> I was hypervigilant all the time. I had to anticipate and be prepared for when he would go into his rages. I felt extremely anxious and worried as a young girl. I was so fearful of him. His behavior was so erratic and unpredictable. He was extremely verbally and physically abusive. As a result, I would blame myself for his behavior. When I was growing up, my father was a police officer. I can clearly remember wishing that he would be killed while on duty and then feeling so guilty for having those feelings. My friends had loving relationships with their fathers.

Participant 1 provided similar accounts of their formative environment. Participant 1 shared,

> My dad was incredibly abusive and just being in the home was unsafe physically, but then add the erratic and irrational fits of rage, I didn't know how to feel at any given moment. I did my best to be a good girl and not get in the way. I was cute when I needed to be and could turn myself into whatever I needed to be at the time. Once we moved my safety needs were covered, but my emotional needs were cared for even less. My mom was checked out of her own life, she certainly didn't have time to check into mine.

Table 7 provided some statements participants made regarding their perceived emotional and safety needs.

Table 4

Emotional and Safety Needs

Participants	Statements Regarding Emotional and Safety Needs
Participant 2	"I felt I was always being watched and didn't feel safe."
Participant 3	"Even after yelling at us, she would make you stick around and act happy so that she didn't have to feel bad about herself."
Participant 5	"We never felt safe."
Participant 6	"Emotions were not expressed unless it was anger."
Participant 8	"My mom controlled me with fear."

Subtheme Five: Distress Symptoms

Participants reported feeling anxious and worried about their parents' behaviors, temperaments and instability. Participants consistently reported a pattern of unstable expectations in terms of emotional support, physical safety and mental health. These

patterns contributed significantly to deleterious conditions for respondents as they attempted to navigate the unchartered waters of their childhood. Examples of participants' statements regarding frequency of distress symptoms are shown in Table 8.

Table 5

Distress Symptoms

Participants	Statements Regarding Distress Symptoms
Participant 2	"I have depressive episodes pretty often."
Participant 3	"Most days in a week."
Participant 4	"These feelings are triggered if I feel overwhelmed and feel like I am not in control."
Participant 5	"Daily"
Participant 6	"Daily, it's a constant struggle."
Participant 8	"Depression- often Anxiety- daily Distress- Rarely"

Theme 3: Meta-Cognitive and Task-Related Skills

A subsequent theme identified during the analysis process was meta-cognitive and task-related skills. This theme emerged in response to question four which inquired how participants rated their ability to manage tasks and challenges. Participants reported substantial difficulty making decisions and assuming responsibility in areas in which they perceived possible scrutiny. Participant 2 wrote in their response, "I had extreme anxiety of failing and was a perfectionist." Participant 4 reported,

> I doubted myself and never felt confident in myself. I was fearful of making decisions and worried about how others would view me. I was always afraid of making a mistake and never felt smart enough. In elementary school, I would "give-up" easily instead of trying to figure something out.

Another respondent indicated that they experienced feelings of doubt and insecurity when faced decisions. Some shared that they would avoid tasks that would seem challenging. For instance, Participant 7 stated,

> I analyzed, questioned and doubted every move I made when I was younger and even most of my adulthood. Reviewing every possible outcome, even after a decision was made, I analyzed and ruminated on the outcome, replayed it in my head. In middle school and teenage years, I just had to push through the doubt or act without thinking or dull my senses with drugs so that my mind slowed and I could act without freezing, could function in social settings, even to get through homework and chores. At times the only thing that shut if off was sleeping.

Several respondents shared similar cognition that indicated significant indecisiveness and failure-aversion. Participant 9 shared, "My thought of self-doubt tends to run in circles until I am comfortable enough with my choice to do or think of something else, but I still tend to return to my indecision later until I have exhausted every other option I could have chosen and that the one I chose was right, or enough at the time." Table 9 demonstrates examples of participants' views regarding their abilities pertaining to their meta-cognitive skills.

Table 6

Meta-Cognitive and Task-Related Skills

Participants	Statements Regarding Meta-Cognitive and Task-Related Skills
Participant 1	"I didn't feel very smart because I never got to focus in school."
Participant 3	"I tend to struggle a bit if things feel safe and stable and supportive, or easy."
Participant 4	"I always struggled with difficult challenges growing up"
Participant 5	"Mum never let us help in the household and frequently made us feel like we are completely useless for anything in "real life"."
Participant 6	"They give me anxiety because I need to be perfect, which I know is impossible."
Participant 7	"I find that I struggle with motivation, confidence and anxiety when things are directed at my own needs"
Participant 8	"I take on every task even if it's more than I can handle."

Subtheme Six: Negative Self-Concept

Negative self-concept surfaced as a significant subtheme in the results. The responses reverberated a common element of belief systems rooted in the notion that participants were defective, inherently bad, deserved bad things, broken, and shameful. Common phrases used by respondents to describe their sense of self were "inadequate," "bad," "broken, disgusting, unlikeable," "failure," "not good enough," and "needy." An example of this was demonstrated by Participant 7 who wrote, "I view myself as a burden, fat, ugly, disgusting, unlovable, undesirable, way too needy, inadequate, a fraud,

weird, alone, tolerated, lost, selfish, a failure, and sexually dysfunctional." Additionally, Participant 7 reported,

> I rarely looked anyone in the eyes in those days, shame, anxiety, disgust, fear, guilt, anger, hurt prevented it. I never felt pretty, I just always felt fat, ugly and out of place. I felt tolerated by the people around me. So, I just smiled, at everything, like it was my shield because no one really noticed. My bruises healed and I slowly just fell into a group. The saving grace was I was always, reading and I always liked learning. I could turn the whole world out in a book, or lost in my head. By middle school, I tested in IB program, and so I because less disruptive and more invisible. Growing up, my self-esteem was bad, I felt unloved and unwanted, I hated myself and I felt I was a burden to everyone.

Participant 4 reported "I always felt that I wasn't good enough." This response was mirrored by Participant 9 described, "I saw myself as broken, that nothing could fix me, that the pieces weren't worth putting back together." The participants' views toward their self-concept impacted their abilities in various ways. Some reported difficulty managing tasks, while others reported approval-seeking behaviors. An example of this was highlighted by Participant 9 who wrote,

> Many of my decisions and actions were chosen for me. My parents dictated my reactions, schedule, and what I was allowed to do. Anytime I was asked of my opinion, I would panic. I was taught that my thoughts should stay to myself; 'If I you can't say anything nice don't say anything at all'…or I would redirect the

> conversation or remain indifferent. On every occasion that I stood alone, figuratively, I would doubt if I was ready or if I was enough.

All of the respondents reported battling feelings of doubt on a consistent basis. Participants reported doubting their abilities to make appropriate decisions. They shared similar accounts of fearing failure and the predominant need to be perfect. These feelings of insecurity and doubt also impacted participants' abilities to make relevant choices in their lives, especially if they were concerned about scrutiny or judgment. Participant 1 described,

> I received constant conflicting messages of who I was as a kid. One person would tell me I was great, another would rip it all to shreds. I have always been afraid to try and even more afraid of failing. I don't know if most kids felt this way, but to me things were life or death and I was going to somehow ruin everything and end up on the bad side of everything.

Participants' statements regarding their perceptions pertaining to their negative self-concept are illustrated in Table 10.

Table 7

Negative Self Concept

Participants	Statements Regarding Negative Self-Concept
Participant 1	"I felt inadequate and insecure and I viewed my very existence as a burden and mistake."
Participant 2	"I also believed that I was "bad" and deserved punishment, constantly."
Participant 3	"I viewed myself as broken, disgusting, unlikeable."
Participant 4	"I never felt good enough and felt there was something wrong with me."
Participant 6	"I was always very hard on myself to be very different than what went on around me."
Participant 7	"Growing up, I view myself as weird, out of place, in the way, ugly and annoying as I went through elementary school."
Participant 8	"I never felt good enough."
Participant 9	"I was ashamed about many aspects of myself."

Theme 4: Resilience

Findings from this study revealed the emergent theme of resilience as well. Participant responses indicated that their abilities to rise above their circumstances and develop survival skills demonstrated a decisive form of resilience in these participants. One participant reported that they realized that they had no other choice but to heal from their traumatic experiences. Another respondent began to view themselves differently through understanding their attachment style. They stated, "Discovering what attachment style I had, immensely changed my relationship and also how I viewed myself."

Respondents reported an increase in confidence in meta-cognitive skills as a result of their ability to regulate emotions as well. Table 11 highlights some of the statements that exemplify participants' resilience.

Table 8

Resilience

Participants	Statements Exemplifying Resilience
Participant 2	"I have overcome many struggles and traumas and continue to heal."
Participant 3	"I think it allowed me to push through a lot of barriers that other people either couldn't, or simply didn't want to."
Participant 4	"I have a strong will to never give up."
Participant 6	"I've grown and will continue to grow and fight for a better life."
Participant 8	"While I don't like to say no to people when it comes to stuff for me, I will push back when it comes to my kids and other kids that I care about."
Participant 9	"I see strength in my efforts and determination to be something other than my past and the things I struggle with daily."

Subtheme Seven: Self-Regulation Skills

Participants shared that they have been able to obtain control over the symptoms of their trauma through techniques and strategies. The responses resulted in the discovery of the self-regulation skills subtheme, which demonstrated that participants utilized several skills to assist them in managing their distress symptoms. The skills that were implemented varied for these participants. Among the most common skills that seemed to provide the most benefits per the responses were therapy and medication. Majority of the

respondents reported that having a secure attachment with their therapist assisted them in the healing journey. Participant 2 wrote

> I started seeking professional help at 15 years old and I am now 25. It has been a decade of struggling with CPTSD, and I now know that I am loved and that I am worth peoples time and efforts. I have learned what real love is and how to love myself. I have learned how to set boundaries and how to say no and that I am allowed to say no. I have healed immensely through DBT and EMDR therapy and I wouldn't be alive today if I didn't have the help from professionals that taught me how to heal.

Another participant wrote, "I continue to do the EMDR therapy to address unresolved memories. It has helped me realize that there wasn't anything wrong with me." Some reported attending trauma-focused groups to support their therapeutic needs. For instance, one shared, "Morning and evening routines, weekly therapy, regular exercise, spending time with my dog, ongoing time in trauma-focused groups, taking days off when I need to, creative outlets."

In addition to therapy, participants learned to establish boundaries that included discontinuing contact with primary caregivers who continued abusive behaviors. For instance, Participant 4 indicated,

> My father is a Narcissist and a very sick man. I have chosen to disconnect from him and my siblings. My siblings have chosen to support and stay with this Narcissist. I have removed myself, my husband and children from this toxic family. It was a very hard decision, but it was the best decision I ever made!

Four other participants also indicated that they have ceased communication with their caregivers. Two additional participants indicated that they have plans to end communication with their caregivers in the imminent future. In addition to boundaries, participants shared techniques of self-talk, recognizing activation of emotions, and practicing exercises that have proven to be helpful to the participants in reducing stress. Table 12 illustrates some of these self-regulation skills.

Table 9

Self-Regulation Skills

Participants	Statements Regarding Self-Regulation Skills
Participant 1	"Therapy and medication help me to keep those lies at bay."
Participant 2	"I go to weekly therapy and I have a strong support system"
Participant 3	"I have gained a lot of emotional intelligence, but only through a lot of hard work and therapy and being in group support setting for C-PTSD."
Participant 4	"I continue to do the EMDR therapy to address unresolved memories."
Participant 5	"Chill with other people with C-PTSD, it helps a lot to be with people who understand it and encourage each other"
Participant 6	"I'll make sure that I do some self-care in the evening. For me that's taking a bath, listening to music, lighting some candles."
Participant 7	"A lot of reading, staying busy, listening to inspirational speeches, spending time playing with my guinea pigs, working out, journaling, therapy, crying, meditating, continuing to understand my symptoms, having self-compassion, massages, engaging in random hobbies and whatever else I find that helps."

Subtheme Eight: Positive Self-Concept

Participants reported that they have been able to identify several positive beliefs about themselves since developing self-regulation skills and establishing healthy connections. Some of these beliefs are as follows: they are loved and worth loving; they are capable human beings; they are deserving; they are fundamentally good; they deserve good things; they are resilient; they are enough. Participants reported that these beliefs are not always unshakeable, yet they are able to recognize activation and challenge threats to these beliefs on a consistent basis.

Participant 9 reported, "I am learning what I enjoy, what makes me comfortable, what makes me uncomfortable, and how to function for myself and not for someone else." Similarly, Participant 4 wrote, "I am strong enough to keep pushing through in spite of everything that I have gone through." Participant 2 reported:

> "I am worth more than what I can give people, I am beautiful, I deserve to eat and to be happy, I am strong, I am a survivor, I am capable, I am accomplished, I am more than my body I am a soul, I am loving and kind, I am caring and compassionate, people wanna (*s/p)* hear what I have to say, people care about how I am, I can trust people and they can trust me, I am loved, I am glad I exist, I am glad I am where I am."

Table 13 demonstrates some examples of how participants view themselves currently.

Table 10

Positive Self-Concept

Participants	Statements Exemplifying Positive Self-Concept
Participant 1	"Ultimately, I know the things I believe about myself are lies."
Participant 3	"Intellectually very intelligent, very competent and at times stubborn and defiant."
Participant 4	"I recognize my strengths and feel good about myself."
Participant 5	"We're good at learning about ourselves and we're good people for going through the pain of self-awareness to be better than our parents and not repeat the abuse"
Participant 6	"I've grown and will continue to grow and fight for a better life."
Participant 7	"Today, the positive belief I have about myself, is that I am smart, I have survived many obstacles."
Participant 8	"I am stronger now."
Participant 9	"Now I'm whole, missing a few pieces, fragile but trying."

Summary

Chapter 4 explored the results of this study which sought to understand the impact that attachment trauma had on the formation of self-concept on the C-PTSD victim. The first research question posed inquired about the lived experiences of C-PTSD victims. The second question asked how attachment trauma shapes the self-concept of C-PTSD victims.

This chapter discussed the process of data collection which included a review of the setting, demographic information, data collection method, and analysis process.

Additionally, this chapter discussed relevant methods to ensure trustworthiness of this study as well as compliance with Institutional Review Board requirements to ensure confidentiality of information.

Based upon the patterns identified from the respondents, it became evident that victims of C-PTSD experienced a range of adverse childhood experience due to significant caregiver limitations. The responses from the participants indicated that caregiver limitations contribute significantly to adversity in childhood, which impacts the quality of attachment. Additionally, responses alluded to significant cognitive distress and distortions, emotional dysregulation and the inability to engage in meta-cognitive skills. The compilation of these systems provides the answers to the second research question concerning how attachment trauma impacts self-concept. Chapter 4 reviewed the relevant themes pertaining to the study. Chapter 5 discusses the implications, limitations, and recommendations for future studies.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this study was to explore the impact and role of attachment in the development and formation of self-concept in the C-PTSD victim. Additionally, I sought to understand, explore, and evaluate the lived experiences of C-PTSD victims. I considered the perceptions, the attachment styles, the cognitions, and meta-cognitive development of C-PTSD victims due to their experiences to understand how these experiences shaped their self-concept and their understanding of themselves.

This research study provided key areas of understanding concerning the pathways between cognition and ability. Direct correlations were found between negative cognitions and believe systems as well as difficulties in task performance. Additionally, these cognitive limitations and meta-cognitive skills were determined to have a crucial impact on self-concept. Caregiver limitations were deemed to influence victims' ability to manage emotions; this resulted in detrimental instances of emotional dysregulation with consequential effect on self-concept as well. Adverse experiences in childhood established environments of emotional insecurity and instability. The compilation of these factors indicates significant trauma in attachment. The results of this study indicate that significant experiences in attachment trauma bear credible influence on self-concept.

In Chapter 5, I interpret the results of the study as well as an understanding of how this study relates to prior studies discussed in Chapter 2. The implications and limitations of this study are also discussed. Finally, this chapter aligns the theoretical framework and discusses recommendations for future studies.

Interpretations of The Findings

The results of this study are consistent with several aspects of existing literature review. For instance, in the area of caregiver limitations and emotional safety, the findings of this study indicated that caregivers did not respond to the emotional safety needs of the participants. Participants reported feelings of anxiety, insecurity, hypervigilance, and other symptoms of emotional dysregulation. Rosmalen et al. (2016) indicated that caregivers are responsible for creating a safe base for their infants in order to promote an environment that is conducive for emotional growth and development. This environment is critical for emotional regulation (Rosmalen et al., 2016). Additionally, children who are taught emotional safety develop neural networks that promote confidence, neutrality, the ability to discern danger and threat, and can make decisions (Bowlby, 1969). Participants of this study did not develop these critical skills and indicated their caregivers did not promote an environment of trust and safety. They detailed accounts of abuse, neglect, violence, and distrust; this created an environment of emotional instability, danger, and disparity. As a result, they were unable to discern danger or threat, did not develop confidence, and failed to regulate emotionally.

Additionally, Riggs (2010) indicated that disorganized patterns of attachment results in cognitive schemas in which a child's internal world is unreliable, unpredictable, and confusing. Children with disorganized patterns of attachment suffer from psychopathological conditions and experience intense symptoms of anxiety, overwhelming feelings of distress and concern regarding their attachment figures, and concern regarding their safety (Gazzillo et al., 2020). Findings from this study

corroborated these points as participants shared that they could not predict their caregivers' responses, they experienced intensity in distress and anxiety symptoms, and they communicated concern regarding their security in their attachments. Participants echoed worries that they never knew if their caregivers loved them or would abandon them. They shared caregivers would stifle their emotional growth, caregivers were unpredictable in their affection and their responses, and abuse from caregivers was imminent. Participants reported that biological, emotional, and safety needs were not always met. These unpredictable patterns led to distress symptoms and consistent patterns of worry, concern, agitation, and unreliability for participants.

Pressley and Spinazzola (2015) reported that the internal working models of C-PTSD victims are severely compromised. This is evidenced by cognitive functioning, affect regulation, interpersonal and social skills, emotional regulation, and processing. Findings from this study support these conclusions. Participants indicated that meta-cognitive skills were significantly limited due to their inability to focus, concentrate, apply critical thinking, and an overriding fear of failure. Emotional dysregulation was also a contributing factor in the limitation of engaging in meta-cognitive skills. Participants reported that their inability to manage their emotions often contributed to lack of confidence in their ability to handle challenging tasks; in other instances, participants indicated when faced with challenging tasks, participants became too overwhelmed to focus. The internal working models of these participants were cloaked in fear of failure schemas as well as instability and lack of safety. Participants shared that they were often afraid to fail and felt the overwhelming pressure to be perfect. Many

reported that they did not want to be seen or have any unwarranted attention. Several reported approval-seeking behaviors. These conflicting pressures challenged their abilities to perform tasks and engage in meta-cognitive skills.

Findings from this study regarding efficacious treatment approaches are supported by current literature. Trauma-based approaches continue to be the most effective in treating the debilitating effects of C-PTSD as reported by Ehlers et al. (2013). Additionally, participants reported supplemental forms of therapy that were effective such as mindfulness, DBT, group therapy, EMDR, and exposure therapy. These therapeutic approaches have been determined to be evidence-based techniques to have the most success among C-PTSD patients (Cukor et al. 2009; Robert et al., 2018; Wampold et al., 2010). Participants reported that EMDR therapy and other trauma-focused therapy in addition to trauma-focused groups have been the most helpful in challenging their symptoms and cognitive distortions. Participants have reported that they have been able to claim a healing path forward due to these therapeutic techniques.

Literature regarding attachment trauma and its impact on self-concept is consistently supported by the findings of this study as well. Chalfin and Kallivaylil (2017) indicated that individuals who endorsed high levels of adverse experiences in childhood reported significant levels of chronic suicidality and self-harming tendencies. Participants of this study reported high rates of distress and emotional dysregulation, suicidality, and self-harming tendencies. Further, participants reported that they experienced abysmal hatred and worthlessness directed internally. They struggled with

impulse-control, self-awareness, cognition, and core areas of functioning. According to Perez et al. (2020), these are normative effects of attachment on self-concept on a victim.

Attachment trauma is the foundation for deleterious conditions in childhood due to patterns in caregiver ineffectiveness that result in abuse, neglect, despondency, and detachment (Cox et al., 2014). Attachment trauma also produces an environment in which infants are unable to meet their safety needs. Infants and young children are unable to fathom their troubled circumstances and begin developing internal working models fortified with apprehension, anxiety, stress, and hypervigilance (Rokita et al., 2018). Cognitive schemas emerge in which distortions cement. Thus begins a pattern of emotional dysregulation and distress symptoms. Cognitive distortions coupled with emotional dysregulation and distress symptoms begin to impact confidence and meta-cognitive skills. The ultimate result is a very damaged and delicate negative self-concept, which is characterized by poor self-image, feelings of abhorrence, the sense of unworthiness, and other cognitions, related to defected sense-of-self.

Limitations of the Study

There are certain limitations that are unavoidable with every study. In the context of this study, the purpose was to evaluate the role of attachment trauma in C-PTSD victims. The participants chosen for this study were in maintenance phases of therapy, this could pose a potential limitation. Additionally, I sought only adult participants, which is another potential limitation. Demographic information was not considered in the context of this study. This could pose a limitation, as specific demographic information could provide additional data that could enhance study results.

For the purposes of this study, participant data that was gathered remained confidential. All participants were obtained from third-party sources. Participants were made aware of process for aftercare in the event of re-traumatization postparticipation. I was not in direct communication with the participants with the exception of email correspondence. Participants emailed their responses to the researcher upon receiving the informed consent outlining details of the study, debriefing process, purpose of the study, and participation requirements. Additionally, participants were required to complete an eligibility criteria form (Appendix A) to confirm they met diagnostic and mental status criteria to ensure safety of participants.

Recommendations

The present study was an interpretive phenomenological study that explored the lived experiences of C-PTSD victims. The purpose of the study was to understand the impact of attachment trauma in the development of self-concept in these populations. The participants of this study shared specific aspects of their experiences that provided critical perspectives necessary for further consideration and understanding. The participants reported that their attachments to their caregivers were unstable and encumbered with emotional pain. Participants identified several accounts of abuse and neglect among other adverse experiences. Several aspects of limitations and impact were identified and provided.

Participants reported that specific therapeutic techniques specializing in trauma provided tremendous benefits in countering the debilitating impact of complex trauma. Many of these techniques include EMDR, dialectical behavioral therapy, group, and

mindfulness. Participants indicated that working closely with their therapist allowed them to explore their trauma in great detail and challenge deeply engrained cognitive distortions. Based on the findings from this study, it is recommended that further research is conducted in the area of therapist attachment and C-PTSD patients to explore how this positive attachment relationship contributes to the progress of the patient. Participants reported positive attachments assisted tremendously in challenging many of the cognitive distortions and even assisted in developing a healthier sense of self. There is presently limited research on exploring client-therapist attachment relationship in the context of C-PTSD populations.

The findings from this study afford additional recommendations. Due to the significance of attachment trauma, it is apparent that attachment trauma effects every aspect of an individual. It would be interesting to explore how attachment trauma results in cognitive pathways that delineate specific disorders. For instance, there is limited understanding concerning the differences between a person developing borderline personality disorder traits and characteristics of a person developing symptoms of C-PTSD.

The participants in this study were adults with a diagnosis of C-PTSD and reported that they were in stable mental health condition. Stable mental health condition was denoted by no episodes of psychosis, suicidal ideation, manic episodes, homicidal ideation, or severe emotional dysregulation within the last year. It would greatly benefit the field of mental health to research the emphasis of attachment trauma in other C-PTSD populations. Primarily, further research is merited in adolescent populations,

marginalized populations, and populations in LGBTQIA+ communities. Further studies evaluating instances of minority stress in addition to attachment trauma could provide extensive information to the field of mental health and broaden the understanding of the complexities that marginalized and vulnerable populations encounter.

Implications

Positive Social Change

This study has potential to impact positive social change on the individual, familial, and societal level. From an individual standpoint, understanding how attachment trauma leads to the development of sense of self in C-PTSD patients can allow individuals with this diagnosis to better understand themselves. Victims suffering from this disorder may have a more comprehensive explanation concerning their cognitive schemas and can begin the process of healing by recognizing that the root of their suffering is not caused by their own defects but is due to severed attachment templates, internal working models, and maps.

This revelation may also impact familial patterns of behavior that transcend generations. Behavioral patterns are generally communicated through generations. Identifying attachment trauma histories has the potential to alter familial lineage of trauma histories through the implementation of therapeutic techniques. This can allow individuals to challenge some of these problematic patterns, thus severing the cycles of addiction, abuse, and adversity that are often the consequences of attachment trauma. Additionally, individuals may be able to learn appropriate attachment styles that could

impact future generations. This could greatly benefit their offspring's upbringing thus impacting future familial patterns.

Society as a whole has the potential to be impacted by this study. Attachment trauma causes significant complications, resulting in emotional dysregulation and the inability to manage distress. Participants reported significant unhealthy coping mechanisms. High rates of suicidal ideation, self-harming, and addictive tendencies were also reported. These factors effect society, and addressing attachment trauma's role may influence and promote social wellness. It also has the potential to treat addiction and attend to the suicide epidemic.

Methodological, Theoretical, and Empirical

Bowlby's (1969, 1973, 1980) theory of attachment was the foundation for this research study. This theory states that attachment serves as the crux of emotional and meta-cognitive development for infants. Attachment is formulated between a caregiver's responsiveness to their infant's needs. Secure responses will result in securely attached infants. Anxious, avoidant, or ambivalent responses will result in those attachment styles accordingly. In addition to developing attachment styles, caregivers help devise a secure base for their infants and are responsible for creating a safe haven. Through their attachments, infants develop internal working models which serve as their primary mode of understanding their surroundings and ultimately, the world around them (Riggs, 2010).

This study was in alignment with the theory of attachment (Bowlby, 1969, 1973, 1980). Participants reported that their attachments with their caregivers were very erratic. They shared numerous accounts of violence, adversity, and abuse during their formative

years. Caregivers were characterized by remarkable limitations that reduced their ability to appropriately provide for the participants' emotional and safety needs. These limitations resulted in cognitive and emotional distress. Participants were unable to navigate the real world due to their impaired internal working models.

For Practice

This study has the potential to impact the field of mental health in its entirety. From a clinical perspective, treatment protocols can implement modalities that hone in on attachment trauma when treating C-PTSD populations in an effort to provide more extensive treatment. This can allow clinicians to target the etiological causes of the diagnosis instead of the symptoms, thus allowing the patients to fully heal and recover from their experiences. Additionally, this may potentially lead to the development of a positive self-concept. Therapeutic approaches can benefit from further understanding of attachment trauma's range of impact on core functioning.

Conclusion

Chapter 5 discussed the results, limitations, interpretation, and recommendations of this study. This study evaluated the role of attachment trauma on the formation of C-PTSD victims. It explored the lived experiences of C-PTSD victims and how these experiences shaped their understanding of their sense of self. The participants in this study provided detailed accounts of their childhood experiences and the adversities they faced. Their accounts of emotional instability, dysregulation, cognitive distortions, and challenges, indicated the significant role that attachment played in the development of their self-concept.

The participants of this study provided greater understanding concerning how their attachments with caregivers have impacted their sense of self. Exploration of key aspects of personality development revealed the devastating toll that attachment trauma rendered on their self-concept. This study provided further insight concerning how self-concept is developed through attachment. The participants in this study detailed many challenges and difficulties that they encountered due to distortions in internal working models created through attachment trauma. From the experiences of the participants, it is indicated that attachment trauma has a decisive impact on the formation of self-concept in C-PTSD populations.

Future studies can result from this study as well. This study has the potential to open the doors to studies involving populations with dissociative disorders, personality disorders, and even offender populations. Exploring the role of attachment in disordered patients has the potential to transform the way mental health professionals conceptualize treatment of diverse populations as a whole.

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Appendix A: Eligibility Criteria

Name: _____

Place of Therapy: _____

- ☐ Are you 18 years of age or older?
- ☐ Do you have a clinical diagnosis of complex posttraumatic stress disorder?
- ☐ Have you been in therapy for a minimum of two years?
- ☐ Are you currently in maintenance phase of therapy?
- ☐ Have you had stable mental health for at least one year (no suicidal behaviors, manic episodes, or psychosis)?
- ☐ Do you have an interest in sharing your experience in a confidential research study?

Method of Contact: _____

Referral for Research:

- ☐ Yes
- ☐ No

Appendix B: Interview Questions

1. Describe in detail your relationship with your caregivers when you were growing up.
2. How do you feel your caregivers provided for your emotional and safety needs appropriately all or most of the time?
3. Describe in detail how you viewed yourself growing up.
4. Describe in detail your opinion of your ability to take on difficult challenges, tasks or assignments
5. Describe how you doubted yourself excessively or more than usual when you were younger.
6. How do you view yourself now?
7. Describe in detail the quality of attachment you had toward your caregivers.
8. What kind of negative beliefs do you have about yourself today?
9. What kind of positive beliefs do you have about yourself today?
10. How often do you struggle with thought and beliefs of self-doubt as an adult?
11. How often do you struggle with symptoms of depression, anxiety and distress?
12. What do you do to maintain a healthy mindset?