Constructivist Self-Development Theory: A Theoretical Framework for Assessing and Treating Traumatized College Students

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Abstract. The authors present a new conceptual framework for assessing and treating traumatized college students. The framework, constructivist self-development theory (CSDT), blends object relations, self-psychology, and social cognition theories. It is founded upon a constructivist view of trauma in which the individual's unique history shapes his or her experience of traumatic events and defines the adaptation to trauma. Within this theory, the authors suggest approaches to setting the frame for trauma therapy, including stabilizing acute symptoms and setting appropriate expectations for treatment. CSDT provides a framework for the systematic assessment and practical treatment of three aspects of the self that are affected by trauma. These include self-capacities, or the ability to tolerate strong affect and regulate self-esteem; cognitive schemas, or beliefs and expectations about self and others in the areas of frame of reference (or identity and world view), safety, trust, esteem, intimacy, power, and independence; and intrusive trauma memories and related distressing affect. Finally, the authors provide guidelines for assessing the need for longer term treatment.

Key Words. childhood sexual abuse, constructivist self-development theory, posttraumatic stress disorder, psychotherapy, rape

Over the past decade, mental health professionals have been increasingly concerned about the profound psychological impact of violence and victimization, including rape and childhood sexual abuse. The prevalence and incidence of date rape and other types of sexual victimization have been documented as a significant problem among college populations.[1] As interest in the field of traumatic stress has grown, it has been necessary to develop new theories and treatment models for understanding and intervening with victimized populations. In this article, we describe a new theory of trauma and adaptation, the constructivist self-development theory (CSDT), its theoretical roots, and the implications of the theory for clinical assessment and therapeutic interventions with victimized college students.

Constructivist Self-Development Theory

CSDT grew out of our interest in the question of why some trauma survivors are shattered by their victimization and others are able to resolve their experiences and return to health. A review of the literature on psychological responses to trauma[2] indicated that sexual abuse survivors are at greater risk for experiencing depression, anxiety, anger, self-esteem disturbances, guilt and shame, sexual dysfunction, and relationship problems than are their nonvictimized peers. But the literature clearly indicates that not all victims experience the same responses and that some fare better psychologically than others. Do these differences in response patterns have to do with a person's pretrauma history or to the unique characteristics of the trauma experience? Can we understand the traumatic state by focusing on the world of people and events or on the inner world of the survivor? These and other questions have led us to spend the last few years developing a theoretical framework for understanding the unique inner experience of trauma survivors that accounts for individual differences in the posttraumatic state and provides a heuristic framework for assessment and intervention.[3]

Rooted in the constructivist tradition, CSDT synthesizes a number of theoretical perspectives. According to Mahoney[4] and Mahoney and Lyddon,[5] the construc-

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tivist perspective is that human beings actively create and construe their personal realities or representational models of the world. This becomes a framework from which the individual orders and assigns meaning to new experience. From this perspective, then, rape, accidents, combat, crime, or other serious stressors are not merely objective events that carry predetermined meanings and predictable responses. Rather, these events can be understood only within the context of the victim's unique meaning system.

A fundamental construct within CSDT is the notion of schemata or schemas. These are beliefs, expectations, and assumptions about oneself, other people, and the world. Schemas are templates that individuals develop through their experience, then use to organize information and future experience. Over time, these schemas come to be associated with specific emotions or feeling states. Research has shown that individuals' assumptions and expectations about themselves and the world around them can have profound implications for their emotional and interpersonal behavior.[6] In essence, we believe that the symptoms of posttraumatic stress disorder (PTSD) and related psychological disturbances reflect disruptions to the individual's unique inner world and, particularly, his or her internal representations of self and world, or cognitive schemas.

CSDT bridges object relations and self-psychology theories with more contemporary theories of social cognition. Within the field of traumatic stress, it is consistent with the work of Epstein,[7,8] Janoff-Bulman,[6,9] Roth and Lebowitz,[10] S. Roth (unpublished data, 1989), and D. Westen (unpublished data, 1989).

CSDT focuses on the impact of trauma on the self and the psychological needs and related schemas that we believe are most affected by the experience of trauma. All of these needs exist within all people. Some are more salient than others for each individual.

The self is the seat of the individual's identity and understanding of how she or he relates to the world and how the world works. Beliefs related to the self are termed *frame of reference* schemas.

Psychological needs motivate behavior, and they are shaped by experience. The following six needs are particularly affected by trauma: (1) *safety*, the need to feel safe and reasonably invulnerable to harm; (2) *trust* or *dependence*, the need to believe in the word or promise of another and to depend upon others to meet one's needs; (3) *esteem*, the need to be valued by others, to have one's worth validated, and to value others; (4) *independence*, the need to control one's own behavior and rewards; (5) *power*, the need to direct or exert control over others; and (6) *intimacy*, the need to feel connected to others through individual relationships and to belong to a larger community.

Frame of reference schemas cross all need areas, in that they shape one's sense of identity or beliefs about who one is (eg, what it means to be a man or woman, a trauma survivor, what kind of person one feels one is) and one's world view (why things happen as they do, why people interact as they do, etc).

Schemas are the cognitive manifestations of psychological needs or the beliefs, assumptions, and expectations related to these needs. For example, we all need to feel safe and secure in the world. Schemas related to safety are our assumptions and beliefs about our personal safety.

A major process concept underlying CSDT is Piaget's[11] notion of assimilation-accommodation. Piaget uses these constructs to explain the increasing differentiation of schemas over the course of the life span. Assimilation refers to the process whereby new information is integrated into existing schemas. For example, when a child consistently interacts with adults who respond to his or her needs, this information is assimilated or "digested" in a way that supports the development of beliefs that people can be relied upon for support and protection (which CSDT refers to as trust schemas). Thereafter, new information is easily assimilated into basic positive trust schemas.

If that same child is beaten, sexually molested, or otherwise badly hurt by a family member, this experience cannot be readily assimilated. The child needs to modify previous schemas through the process of accommodation. He or she may eventually come to believe that adults are not very trustworthy and that one cannot always rely on others for support and care.

In general, we believe that trauma that occurs in the critical developmental periods of early childhood and young adulthood, when basic schemas are developing and identity is still fluid, is most likely to produce pervasive disturbances in the six need areas. The areas in which schemas are disrupted will depend upon the individual's unique life history, including his or her social and cultural context. The specific constellation of schemas will be associated with different affective states and symptom pictures.

An important aspect of the CSDT perspective is that trauma is defined by the individual, rather than by the facts of the event. Psychological trauma, by definition, requires an accommodation in core schemas about the self and the world. Thus, although certain events may have more potential to be experienced as traumatic than others, we believe that events are traumatic to the extent that the individual perceives them as traumatic and, most specifically, to the extent that trauma disrupts an individual's central psychological needs and related schemas about self and world, including frame of reference schemas.

The development of the self, or one's sense of identity and the seat of inner life, is a lifelong task, and one that is of central interest to CSDT. Healthy early childhood development results in an individual with solid self-esteem and the capacities to tolerate strong affect, to modulate self-loathing, and to be alone without being lonely. Early trauma can impede this development; later trauma can disrupt the identity as well as the self-capacities.

Setting the Frame for Therapy With Acute Trauma Survivors

Managing acute symptoms of distress. Stabilization is often a necessary first step with survivors of acute traumas and survivors of multiple or chronic traumas who are experiencing external stressors or triggers that are precipitating conscious or unconscious memories of previous abuse. To resolve traumatic material, clients cannot be flooded with unmanageable affect or engaging in dangerous self-destructive behaviors. Overall, this process of stabilization should involve actively identifying all the resources (personal, social, environmental, etc) the client can mobilize during the period of acute posttrauma response, and later, as necessary.

The following guidelines can be useful in working through the process of stabilization:

- Learn what internal and external resources the client needs to promote adaptive functioning.
- Spend enough time before the end of the therapy hour to assess what the acutely distressed client needs immediately and in the near future to feel safe, in control, and supported by others.
- Explore what survivors need to do when they experience suicidal or self-destructive feelings. For example, some clients find it useful to work with the therapist to develop a plan about whom to turn to, where to go for extra support, or ways to find a safe place.
- Establish a safe physical environment, which may be essential for rape or other crime victims before they can talk about the trauma. This may mean staying with friends or relatives, changing the locks, sleeping with a night light, or other practical solutions.
- Address anxiety and sleep disorders with a variety of aids, including guided imagery and relaxation tapes for sleep or the temporary use of antianxiety medication.

Building an alliance based on respect for the individual. Our therapeutic approach with trauma victims is to be as involved and engaged as is possible without violating therapist-client boundaries. Most clients who have been severely traumatized want and need to experience a relationship with a real, warm, concerned human being who is actively involved with them in an empathetic, responsive way. As a result, a more active, open stance may be necessary for building an alliance with these clients.

In the initial alliance-building stage of therapy, we feel it is important that the trauma therapist convey (1) hope about ultimately resolving the trauma, (2) a willingness to be an active guide in the healing process, (3) a capacity to tolerate painful emotions and memories without either distancing or overreacting, (4) a sense of compassion and understanding for the victim's unique experience, and (5) a clear sense of direction in the recovery process.

Educating the client about trauma and therapy. We value psychoeducational approaches as a way of providing survivors with a framework for understanding the effects of trauma and setting expectations for the therapy process. Healthcare providers and health educators can normalize the student's reactions by teaching about what PTSD is, the way trauma reactions are manifested in different people, the fears that people commonly have when they experience these symptoms (eg, going crazy, losing control, regressing), and the prognosis with appropriate treatment, given the individual's background and resources.

It can also be useful to educate students about the approach-avoidance processes of posttrauma reactions by saying something like, "Some days you may feel numb (deadened, like your feelings have died), and the next day you may feel that you're back to your normal self. Then suddenly something will happen inside you or outside of you that will trigger a memory. You may find yourself flooded with painful images of what happened and intolerable feelings. It is perfectly normal to fluctuate between these two very different states. As we learn more about how and when you experience these different states, we will gradually work to make the extremes less intense, painful, and unpredictable."

Because students are accustomed to homework assignments and the use of reading materials, bibliotherapy, which involves suggesting readings related to the student's trauma experience, can be a useful adjunct to therapy.

It is helpful for healthcare providers to discuss the course of therapy with the student, outlining preliminary predictions about the length of treatment, treatment approaches, and potential obstacles.

Setting realistic expectations of treatment. The therapist should acknowledge to the survivor that it is impossible to remove the traumatic experience from the individual's past or from memory or to completely restore the pretrauma frame of reference. With appropriate treatment, however, many students can expect to recall their traumatic experiences with less terror or rage than they may feel at the beginning of therapy.

Helping the student acknowledge the trauma. The therapist also should acknowledge the survivor's ambivalence about being in therapy and opening up such painful material. Student survivors may find the metaphor of an infected wound to be useful—one needs to open it up to heal it, and this will involve pain. Reassure the student that this process will be handled gently and that one can move away from painful material as necessary.

The issue of control is often central for the survivor who is feeling very helpless and powerless. Remind the student that you want him or her to have control over the healing process. We will often say something like, "I am a guide, but you are the captain." Convey a desire to

proceed in a way that is gentle, nontraumatizing, and that helps the student feel in control.

Some survivors find it very frightening to share the details of their traumatic experiences. We let clients know that they need not talk before they are ready. We explore what they imagine it might be like if they were to discuss the details of their experience and help them examine their fears about losing control and consider what would make it easier, safer, and less frightening to talk about details in the session. Clients often struggle with the issue of how much they must remember or share about their experiences. Our answer to this is a very individual one: Each person needs to remember as much as is sufficient for him or her to have a sense of understanding what happened and why it happened. Each person needs to talk about what happened, in and outside of therapy, as much as is necessary to feel heard, acknowledged, validated, and accepted.

Together, helper and student should explore the student's internal process for handling strong feelings. Does she or he tend to avoid strong feelings; devalue himself or herself for having painful feelings; use alcohol, drugs, or food to self-soothe; engage in other self-destructive behaviors? What helps and what doesn't help when the student is feeling distressed?

We also advise directly confronting the student's fears about falling apart. For example, it is often helpful to reassure students that they are not going crazy, that it is normal to have these reactions, that this process is necessary in order to heal. It may also be helpful to explain that the dread of painful emotions is what makes it feel overwhelming and that if one accepts the feelings and goes with them, in a safe place, the fears about experiencing the pain, and the pain itself, will decrease over time.

In summary, a framework for understanding the effects of trauma and the healing process helps survivors gain a sense of control over the overwhelming emotional effects of trauma.

Self-Work

Once the student is out of the acute crisis phase, the important task for the helper is to begin to assess the student's ability to tolerate strong affect, to moderate self-loathing, and to be alone without being lonely. These are the self-capacities that are essential to the individual's ability to engage in the demanding work of trauma recovery and to restore or build a positive sense of self-esteem. The work of developing these self-capacities, which are generally disrupted by trauma, includes learning to know and value oneself.

We encourage trauma survivor clients to begin to learn about and value themselves by spending time engaging in activities they enjoy, connecting with others whom they trust, writing in a journal, engaging in creative activities, and learning to identify and name their feelings. For some individuals, time alone can feel terrifying. We help people develop the capacity to be alone initially by structuring very brief solo activities. In work with student survivors, it is essential to attend to the signs that self-work is needed and to refrain from uncovering more traumatic material during periods in which the student is highly distressed. With clients whose self-capacities are severely impaired, or during difficult periods of therapeutic work, we often start each session with a discussion of ways the client took care of herself since the previous session and end the session with a discussion of what she will need and how she can get it during the hours and days ahead.

Assessing Disrupted Needs and Related Schemas

All people hold schemas in all six need areas. They can become disrupted by trauma in a variety of ways. Trauma survivors often develop overgeneralized negative schemas. Without treatment, the student survivor can come to hold the belief, for example, that all people are untrustworthy, rather than the more limited and less disruptive belief that some people should not be trusted in certain situations. These two types of schemas have very different implications for the individual's relationships with others. Overgeneralized negative schemas are likely to be related to serious disturbances in psychological adaptation and interpersonal relationships.

Schemas that are unresponsive to new information can also lead to interpersonal problems for the student survivor. A victim of date rape for whom trust schemas are extremely disrupted may find it difficult to take in information that is discrepant with these schemas. This woman might meet many "nice" (nonviolent) men who could potentially be reliable and supportive friends. The heightened sensitivity to being betrayed, however, may make it difficult to make these discriminations.

A third type of problematic schema is represented by schemas that are fragile or vulnerable to repeated disruption. Individuals generally tend to interpret interpersonal information in a way that supports or confirms existing schemas. A rape survivor with negative safety schemas may be especially tuned in to information published in the campus newspaper about the incidence of date rape, confirming her perceptions that the world is a dangerous place. As a result, she may retraumatize herself by taking in new information in a way that further confirms her disrupted sense of safety.

Recurrent themes that emerge over the course of therapy reflect the individual's central areas of schema disruption. These themes may be expressed directly through statements; indirectly, through mood and behavior; or symbolically, through recurrent dreams, nightmares, or trauma memories. The assessment of specific areas of disruption for the student survivor takes place through listening for these themes in the clinical material and in the particulars of the traumatic memories. In the appendix, we list specific beliefs, emotional states, and behaviors that reflect disruptions related to identity and world view (frame of reference) and the six need areas.

Resolving Disrupted Schemas

Therapeutic schema work involves gently challenging schemas that are disruptive to the individual's functioning and providing experiences within the therapy and the outside world that gradually lead to the development of new, more positive schemas.

Core schemas that have been disrupted often change through experiential learning, that is, discrepant experiences that challenge one's disrupted beliefs about oneself and the world. For example, student survivors may need to learn gradually that the world is not always an unsafe and malevolent place and that people don't always betray you if you allow yourself to get close to others.

Our approach to developing possible new experiences with clients depends upon their central schema areas. The following guidelines are designed to address disruptions in each schema area:

Safety

- Helping the survivor find both concrete and symbolic ways of feeling safe
- Initiating systematic desensitization and a gradual mastery of feared situations
- Encouraging actions to decrease the sense of vulnerability, including going to self-defense classes, installing burglar alarms, and buying a watchdog
- Learning how to establish boundaries between oneself and dangerous others and behaving in an assertive way in response to boundary violations
- Using guided imagery or relaxation tapes focused on finding a safe, protected, soothing place within one's mind that is a haven during times of distress

Trust

- Learning that trusting others is not an all-or-nothing process but something that needs to be developed slowly through appropriate testing behavior
- Exploring what the student needs to reestablish trust within his or her relationships
- Reestablishing ties with friends who are supportive and trustworthy
- Testing trust in the therapeutic relationship and working through fears of being betrayed or violated

Independence

- Encouraging healthy ways in which the survivor can become more independent while balancing this with the equally healthy need for support
- Mobilizing one's fighting spirit through social activism, turning one's trauma into a gift for others, taking a stand on important personal and social issues
- Finding opportunities to reassert one's independence in safe ways rather than restricting one's activities
- Learning to have compassion for the self that may temporarily feel more helpless, out of control, and in need of support

Esteem

- Promoting group therapy or self-help groups as a way of changing disrupted esteem schemas; for example, students can interact with other survivors who struggle with issues of self-blame and shame
- Facilitating an internalization of the therapist's regard for the individual's many strengths and assets
- Encouraging participation in activities of which the survivor feels proud and that promote mastery and self-esteem
- Finding ways of reconnecting with the lost parts of the self that the student valued and cherished in the past

Power

- Helping controlling and overcontrolled students understand that the need to dominate is a defense against underlying feelings of vulnerability, sadness, or pain
- Encouraging involvement in activities that support a healthy sense of mastery over one's environment and relationships
- Promoting involvement in political causes, such as "Take back the night," which can restore a disrupted sense of power

Intimacy

- Participating in survivor groups can help survivors feel "I'm not alone," 'I'm not a freak"
- Reconnecting with old friends, becoming involved in supportive social/religious/political groups

Frame of Reference

- Exploring specific ways in which trauma disrupted the sense of identity. For example, questions such as "How are you different now, what changed, what about your old self do you miss, how might you imagine reclaiming your former self and all that you valued about yourself?" are ways of exploring disruptions to one's identity
- Identifying and exploring ways in which one's gender identity or sense of comfort with one's gender may have been disrupted by the trauma, such as feelings of confusion about what it means to be a man or woman in this culture or subculture within the context of one's victimization
- Helping the survivor understand how she or he made sense of the experience and how these attributions may have particular costs/benefits. For example, self-blame may be adaptive to the extent that it protects one from the terrible reality that violent events may happen randomly. However, it may be maladaptive to the ex-

tent that it produces feelings of guilt, shame and self-loathing

Other suggestions for resolving disrupted schemas, such as through the therapeutic relationship, are described in depth elsewhere.[2,3] All of these approaches need to be discussed with the student and modified, depending upon the individual's coping resources and social support system.

Overall, we recommend that helpers be creative in exploring ways that the student can restore previously positive schemas about the self and the world. Each survivor will have different schema areas that are more or less salient for him or her, depending upon life history, social-cultural context, and personal resources.

Managing Intrusive Imagery

For the acute trauma survivor, as well as for survivors of chronic traumas who are now dealing with the emergence of traumatic material, it is essential that we help the student survivor manage these recollections so that they are not overwhelming to the recovery process. The following are general guidelines for assessment of memory disturbances and clinical management.

Explore with the student when the instrusive images or flashbacks emerge. For example, do they tend to occur at night? While the student is alone? Are they triggered by certain people who remind the student of the perpetrator, by television shows, climate (eg, a muggy night), smells (alcohol on someone's breath)? Understanding the specific triggers to the emergence of memories is often a relief because these links are frequently unconscious. When they are made conscious, the student can begin to understand his or her responses in ways that enhance the experience of safety and control.

Once the triggers are identified, explore ways the person can cope actively with the memories. It can be helpful to work with the student to regulate exposure to situations that trigger memories. One might, for example, want to avoid reading every newspaper account or seeing a movie about rape or otherwise overexposing oneself to traumatic material.

Developing an emergency plan for times of great distress can also be very useful. This may include thinking through such questions as "Whom can I call? Where can I go for support? What do I need right now?" It is important to spend some time at the end of each session exploring with the survivor what he or she needs to calm and soothe himself or herself when distressed, how to mobilize resources when the memories are overwhelming, and so forth.

As a short-term coping strategy, some people may find distraction useful—engaging in school activities, doing homework, or working crossword puzzles. Encouraging students to think ahead to the future rather than dwelling on the past can provide distraction from intrusive memories and can also provide the groundwork for self-building.

Transforming the dreaded images into something less threatening can enhance a feeling of control and mastery. Examples of imaginal techniques include having the student transform the perpetrator into a toad, imagining himself or herself being surrounded by white light while in frightening situations, or imagining the perpetrator being frozen and disintegrating. These are some of the images that survivors have spontaneously developed in therapy that have helped them manage frightening, intrusive images. It is important not to impose the therapist's own ideas on the student but, rather, to help the student find creative ways of transforming the traumatic imagery.

As the student survivor is increasingly able to cope with the painful, intrusive memories, she or he must eventually probe into and express the painful imagery in some detail. For example, asking student clients questions such as, "What do you see, can you describe the pictures in your mind? Can you describe what you are smelling, hearing, sensing?" can help gain access to the imagery system of memory. Because imagery is the gateway to the emotions,[12] this work should only occur once the person has sufficient inner resources or self-capacities to cope with the powerful feelings that emerge. The helper must be calm and soothing when the survivor is recalling an emotionally charged traumatic memory. For example, while the person is crying, the helper might gently say, "Of course you feel sad; you were badly hurt." Reassure students that they are doing important work and that they have considerable resources to draw upon. Reminding survivors that they have already endured the trauma once and survived it can also be helpful as they struggle with a dread of opening these painful memories.

If a student is panicking during a recollection, the helper should ground him or her to the present reality and to the helper's presence. For example, the client may be directed to focus on some object in the room or be reminded of the helper's presence and protection: "I'm here with you—they can't hurt you anymore." Explore what the student needs to do to feel safe and grounded in reality here and now.

Art work, journal writing, and other expressive techniques are often used to help express feelings and images that are difficult to put into words. These approaches can also help people regulate their exposure to the traumatic material in ways that facilitate mastery. For example, some students may find it helpful to write down their images but want to keep the writings locked in the therapist's file cabinet until they feel it is safe to approach this material again. In this way, the student can titrate his or her exposure to the traumatic memories.

It is very important to explore techniques for backing away from painful memories before the memories become too overwhelming, otherwise some student survivors may retraumatize themselves by becoming too immersed in the traumatic material. Some techniques for assisting in backing away are taking planned "vaca-

tions" from the memory work and devoting time to nurturing oneself, agreeing to move to safer ground during the next session and acknowledging this openly as a way of taking care of oneself, using imagery to move away temporarily from threatening material (eg, one can go to one's "safe" place in one's mind through imagery), and developing ways of soothing and calming onself through self-nurturant behaviors.

When to Refer for Longer Term Therapy

The focus of this article has been on helping college students who have experienced an immediate, acute traumatic event and who presumably have sufficient resources to draw upon to benefit from time-limited, crisis-oriented approaches. There are times, however, when brief treatment approaches cannot adequately address the often-devastating and longer term effects of trauma. The following guidelines often point to the need for longer term therapy. (1) A history of childhood abuse emerges in therapy in the course of the exploration of the current trauma. (2) The individual continues to be overwhelmed when exploring the traumatic material or continues to regress to less adaptive ways of functioning. (3) A pattern of such self-destructive, regressive behaviors as suicidal tendencies, eating disorders, substance abuse, sexual acting out emerges. (4) One or more central schema areas continue to be seriously disrupted. For example, the client persists in feeling chronically unsafe, helpless, and unable to trust others who were previously trusted in a way that is disruptive to his or her personal or interpersonal functioning.

We must acknowledge that the effects of trauma are profound, having a potential impact on many areas of one's personal and interpersonal functioning. Although we use a brief treatment model for many survivors of acute traumas, we also recognize that continued therapy may be needed at some future time. Both therapists and health educators can inform students who are about to stop counseling about the possible need for continued therapy and also describe some of the signs that may indicate the need to go back into treatment. This can help to normalize future responses. We often tell clients that they might experience an exacerbation of symptoms around anniversaries or other reminders of the trauma or during other major life changes, such as getting married or having a child. We hope that the current therapy experience has been positive to the extent that the student will be amenable to seeking future treatment and will not feel ashamed or deeply distressed about any exacerbations that may occur.

In summary, CSDT provides a map for understanding individual differences in adaptation to trauma, a map that is respectful of the survivor's unique needs and areas of vulnerability. It can serve as a basis for assessment, treatment planning, and intervention with traumatized college students as well as other survivors of victimizing life events.

APPENDIX
Beliefs, Emotional States, and Behaviors Reflecting Disrupted Schemas

Disturbed Frame of Reference Schemas

The belief that the trauma was an inevitable outcome of one's tragic fate
The belief that the world or life is no longer meaningful or coherent
An obsessive need to search for answers to the question "Why me?"
The belief that chance factors or randomness accounts for events
A generalized loss of hope
Statements such as, "I'm not the same person as I was before," "The old me is dead," "Something in me died"

Disturbed Safety Schemas

A sense of unique vulnerability to future harm
Chronic anxiety or vigilance in strange situations
Concerns about being able to protect oneself from specific or vague threats in the future
A sense of danger that has overgeneralized to a number of life situations
The belief that the world is unpredictable, dangerous, and uncontrollable
A belief that one is a "magnet" for danger or harm
Compulsive behaviors aimed at enhancing safety, such as repeatedly checking door locks
Avoidance of situations that symbolize danger

Disturbed Trust/Dependency Schemas

The experience of feeling betrayed or abandoned by others
The expectation that other people will disappoint or let the person down
The fear that others will make a fool of one
The expectation that people will hurt the person if given the opportunity

Disturbed Independence Schemas

A general devaluation of oneself for being weak, helpless, vulnerable, needy, dependent
Statements about how important it is that the person resolve difficult situations or be strong enough to cope with any crisis on her own; a reluctance to ask anyone for help or to acknowledge that she needs help from others
A strong desire to be self-sufficient
Feeling trapped and restricted
A dread of helplessness or vulnerability

Disturbed Power Schemas

A belief that one cannot control future outcomes in interpersonal relationships
The belief that one must be in control of others
The belief that others desire, expect, or need to be dominated, controlled, or oppressed

Disturbed Esteem Schemas

References to the self or parts of the self as bad, damaged, flawed, or evil
The belief that one is responsible for destructive actions or events
Expressions of profound guilt or unworthiness
The belief that trauma occurs because of something about the victim

The belief that other people are basically bad, evil, or malevolent

Disturbed Intimacy Schemas

Feeling lonely, cut off, alienated from others or the world
Feeling as if the part of oneself that cares for others has died
An inability to feel engaged with activities that were formerly pleasurable
Great difficulty spending time alone

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