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Dysfunctional Schema Modes In A Low-Income Clinical Population In A Psychological Care Center In The City Of Poza Rica, Veracruz

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ABSTRACT

Schema therapy has undergone a significant evolution in recent years, offering a highly valuable framework for elucidating the intricacies of pathological personality dynamics. This is a domain where other theoretical approaches often fall short in terms of clarity. The concept of mode plays a pivotal role in this model, particularly in the diagnosis and treatment of disorders that were previously considered challenging to manage, including characterological disorders and other chronic clinical disorders. The objective of this study is to delineate the most prevalent coping strategies employed by individuals within a clinical population who applied the psychological care services provided by a public facility, namely the Faculty of Psychology of the Universidad Veracruzana, in the City of Poza Rica, Veracruz. The results indicate that females display a higher frequency of the Vulnerable Child and Angry Child modes, which suggest intense emotions and unmet emotional needs. In contrast, males exhibit a higher frequency of the Angry and Impulsive Child modes, which indicate tendencies towards impulsive and aggressive behaviors. Therefore, it can be concluded that both genders exhibit dysfunctional critical modes, but that females tend to be more self-demanding.

Keywords: Schema therapy, Pathological personality dynamics, Dysfunctional critical modes

INTRODUCTION

There is a dearth of studies in Mexico that delineate the psychological characteristics of low-income clinical populations in accordance with the tenets of schema therapy.

The study of dysfunctional modes facilitates a more comprehensive understanding of the cognitive, emotional, and behavioral variables of low-income individuals who recognize their own alterations in these areas and seek professional assistance.

In light of the rising prevalence of mental health issues across the globe and the particular historical and sociocultural context of the northern region of the state of Veracruz, it is crucial to gather data that can shed light on the core tenets of schema therapy. This encompasses unmet emotional needs, early maladaptive schemas, parental behaviors that give rise to these schemas, and the dysfunctional modes that perpetuate them.

The low-income population of the City of Poza Rica, Veracruz, is exposed to a multitude of risk factors pertaining to mental health. These include poverty, a lack of access to education and health services, unemployment, and insecurity.

These psychosocial risk factors have a significant impact on an individual's psychological development, increasing the likelihood of experiencing toxic frustration of emotional needs, victimization, mistreatment and traumatic events during childhood and adolescence. These experiences have been linked to the emergence of early maladaptive schemas and dysfunctional coping mechanisms.

An understanding of the way these variables manifest can inform strategies for enhancing protective factors that directly and positively influence mental health. These include the satisfaction of basic emotional needs during parenting, which increases the probability of developing healthy coping patterns and modes.

METHODOLOGY

The present study analyzed the results of 47 patients, 14 of whom were male and 33 of whom were female, with an age range of 19 to 58 years. The patients were evaluated at a psychological care center coordinated by a public university in the city of Poza Rica, Veracruz. The Schema Mode Inventory (SMI 1.1), created by Jeffrey Young, was used to assess the patients.

The instrument evaluates 14 different schema modes, which are divided into six innate child modes, five maladaptive coping modes, two dysfunctional parent modes and one healthy adult mode. These can be classified into the following categories: The levels of functioning were classified as follows: very low, average, moderate, high, very high and severe.

The objective was to ascertain which dysfunctional modes of schema occur with greater frequency and severity in this population and to determine whether there are significant differences based on gender.

Theoretical framework

The concept of mode has its origins in Schema Therapy, a therapeutic approach developed by Jeffrey Young. It was designed to address character disorders that are challenging to treat. In order to gain an understanding of the concept of mode, it is necessary to first consider the concept of schema.

Early maladaptive schemas

As posited by Young (2003), within the domain of cognitive development, a schema may be defined as a cognitive construct that is imposed upon reality or experience. This construct serves to facilitate the processes of explanation, perception, and guidance in response to external stimuli. Some of these schemas develop primarily as a result of adverse childhood experiences and are at the core of personality disorders and psychological disorders in general. These are referred to by the author as 'early maladaptive schemas'.

The characteristics of these early maladaptive schemas can be defined as follows: they are composed of memories, emotions, cognitions, and bodily sensations; they refer to oneself and one's relationships with others; they are developed during childhood or adolescence; they are elaborated throughout life; and they are dysfunctional to a significant degree (Young, 2003).

It can be stated that maladaptive behaviors are developed as a result of responses to a schema. It can therefore be concluded that while behaviors are driven by schemas, they are not themselves part of the schemas.

Patients tend to regard schemas as a priori truths, which consequently influence the processing of subsequent experiences. These schemas play an important role in how patients think, feel, act, and relate to others. Paradoxically, they lead patients to recreate in their adult lives the childhood conditions that were most harmful to them.

Schemas are the result of central emotional needs that were not met during childhood. The five most important needs are: secure attachments to others; autonomy, competence and a sense of identity; freedom to express valid needs and emotions; spontaneity and play; and realistic limits and self-control.

Four categories of early life experiences have been identified as encouraging the acquisition of schemas. These are: toxic need frustration (experiencing an insufficient supply of a beneficial factor), traumatization or victimization, experiencing a substantial amount of a positive stimulus, and selective internalization or identification with significant others.

The 18 early maladaptive schemas proposed by Young are associated with different domains, which correspond to unmet emotional needs in childhood and adolescence.

Disconnect and reject domain

1. Abandonment/Instability
2. Distrust/Abuse
3. Emotional deprivation
4. Flaws/Embarrassment
5. Social Isolation/Alienation

Domain of deterioration of autonomy and performance

6. Dependence/Incompetence
7. Vulnerability to Damage/Disease
8. Tangle/Undeveloped Self
9. Failure

Impaired boundary mastery

10. Law/Grandiosity
11. Insufficient self-control/self-discipline

Dominance of the direction of others

12. Subjugation
13. Self-sacrifice
14. Seeking Approval/Seeking Acknowledgment

Supervisory and inhibition domain

15. Negativity/Pessimism
16. Emotional inhibition
17. Relentless Standards/Hypercritical
18. Punishment

Patients develop maladaptive coping styles and responses at an early age in order to adapt to schemas, thereby avoiding the intense and overwhelming emotions that schemas typically engender.

Schema therapy distinguishes between the schema itself and the strategies an individual employs to cope with it. Therefore, behavior cannot be considered part of the schema; rather, it is a component of the coping response. The schema is the primary determinant of behavior.

Maladaptive schema modes

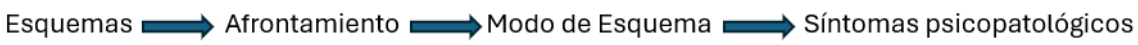
Personality is conceptualized as a group of distinct "parts" with potentially separate affective, cognitive, behavioral, and motivational qualities (Brockman, Robert N.; Simpson, Susan; Hayes, Christopher; van der Wijngaart, Remco; Smout, Matthew, 2023).

Schema modes are the moment-to-moment emotional states and coping responses, adaptive and maladaptive, that are experienced by all individuals. Young and colleagues define schema modes as "those schema schemes or operations, adaptive or maladaptive, that are currently active for an individual" (Young, Jeffrey E.; Klosko, Janet S.; Weishaar, Marjorie E., 2003: 37). Often, our schema modes are triggered by life situations that elicit a particularly strong response.

A dysfunctional schema mode is activated when specific maladaptive schemas or coping responses have erupted into distressing emotions, avoidance responses, or self-defeating behaviours that take over and control an individual's functioning.

Young identifies ten schema modes, although several others have been identified since then. This is due to research and theoretical development expanding the modal model to better explain a wider range of psychopathology (Brockman et al., 2023).

A schema mode is the combination of a schema that is triggered and a coping response. Indeed, the manner in which modes relate to schemas is contingent upon the specific coping strategy employed. The relationship between schemas and modes is subject to mediation by the chosen coping style (Arntz, A. & van Genderen, H., 2013).



(Arntz, et al., 2013: pp. 14-15).

The term 'schema mode' is defined as the current emotional, cognitive, and behavioral state that an individual is in. Dysfunctional modes are most frequently observed when multiple maladaptive schemas are activated (Farrell, Joan M.; Reiss, Neele; Shaw, Ida A., 2014).

Farrell et al. (2014) note that modes are often triggered by events that patients experience as highly emotional. In patients suffering from severe personality disorders, modes can change rapidly, resulting in sudden behavioral modifications or seemingly disproportionate reactions. These are a source of patients' interpersonal difficulties and emotional and behavioral instability. However, modes can also remain rigidly rooted.

Negative coping responses are commonly manifested in the form of aggression, hostility, manipulation, exploitation, dominance, recognition-seeking, stimulation-seeking, impulsivity, substance abuse, submission, dependency, excessive self-sufficiency, compulsiveness, inhibition, psychological withdrawal, social isolation, and situations. The concept of emotional avoidance can be elucidated through the lens of modal theory. The symptoms of personality disorder can be described and understood in terms of the functioning of modes (Farrell et al., 2014).

In their analysis, Eckard Roediger et al. (2018) highlight that modes represent the manner in which schemas manifest following modification by schema coping styles. A single mode may manifest as the expression of multiple schemas and incorporate different coping styles.

Modes serve to consolidate the intricate nuances of underlying schema processes into a manageable number of states, with the potential for an unlimited number of modes (as evidenced by the growing number of modes described in the schema therapy literature) (Roediger et al., 2018).

Arnoud Arntz and colleagues differentiate between modes associated with predominantly negative emotions and modes employed to cope with these emotions (Arntz et al., 2013).

The fundamental, innate child modes are the Vulnerable Child, Angry Child and Impulsive Child, which are innate responses to unmet needs. As such, they express basic emotions, and thus have a distinctive character.

The fundamental maladaptive coping modes are the Avoidant Protector, the Overcompensatory, and the Complacent Surrendered. These are survival responses to trauma or unmet needs, which manifest as flight, fight, or paralysis. Such behaviors are manifested as a consequence of the child's interaction with and internalization of critical modes, including current thoughts and social emotions.

The fundamental modes of dysfunctional criticality in the parental figure are characterized by a punitive and demanding disposition. These modes are the result of the selective internalization of negative aspects of significant others in childhood and adolescence. They serve to preserve the internalized central messages, beliefs and judgments of other important people that the child hears from infancy.

It should be noted that there are also healthy modes, namely the Healthy Adult and the Happy Child. However, the focus of this paper is on the maladaptive or dysfunctional modes that were previously outlined.

Child-modes

As posited by Young et al. (2003), child modes are an inherent aspect of the human condition, encapsulating the full spectrum of emotional experience.

As elucidated by Roediger et al. (2018), the activation of a schema evokes a sense of temporal displacement, wherein the individual experiences a sense of returning to a past event or situation that bears resemblance to a childhood memory. The adult regresses to a state of childhood. Accordingly, this state is designated as "child mode."

In their 2020 study, Loose et al. (2020), Ruth define infantile modes as expressions of emotion and behavior that occur prior to any form of upbringing or guidance. Such individuals typically exhibit primal emotions. In the event of chronic frustration of needs, the child's modes become more intense, maintaining a connection between emotions and memories with the core schemas.

Farrell et al. (2014) highlight that these "infantile modes" are characterized by intense feelings such as fear, helplessness and anger. Young et al. (2003) identified four modes of child behavior: the vulnerable child, the angry child, the impulsive/undisciplined child, and the happy child.

Vulnerable Child Mode

Vulnerable Child mode can be conceptualized as a repository of early maladaptive schemas, wherein the individual experiences the associated emotional states and unmet emotional needs, but without the capacity for a Healthy Adult perspective (i.e., without a stable sense of self that transcends transient emotional states and allows for confidence in one's ability to cope). (Brockman, RN. et al., 2023)

A patient in Vulnerable Child mode may present with behaviors such as fear, sadness, feeling overwhelmed or appearing helpless. This mode can be conceptualized as a child in need of care and protection yet lacking the necessary support to survive (Young, J. et al., 2003). Additionally, they may experience feelings of loneliness, isolation, lack of support, confusion, and insecurity (Loose, Ch. et al., 2020).
Arntz, A. et al. (2013) provide a detailed characterization of the nuances associated with the vulnerable child. For instance, in the Lonely Child mode, the patient typically experiences an emotional emptiness, loneliness, social rejection, and a sense of unworthiness. In the Abandoned and Abused Child mode, the patient may endure emotional distress, a fear of abandonment and abuse, feelings of desperation, a sense of victimization, and a perception of being useless, while also exhibiting an intense desire to find a parental figure to provide care. In the Humiliated/Inferior Child mode, a subform of the Abandoned and Abused Child mode, the patient experiences a reduction in feelings of abandonment but instead feels humiliated and inferior in relation to childhood experiences within and outside the family. In the Dependent Child mode, another subform of the Abandoned and Abused Child, the patient feels unable to meet the responsibilities of an adult, displays strong regressive tendencies and seeks to be cared for. This mode is related to a lack of autonomy and self-sufficiency caused by an authoritarian upbringing (Arntz, A. (Arntz et al., 2013). (Arntz, A. et al., 2013).

Angry Kid Mode

The Angry Child mode is characterized by the experience of intense negative emotions, including anger, rage, frustration, impatience, and outrage. These emotions are expressed directly in response to perceived unmet needs or unfair treatment related to associated schemas, including abandonment, distrust/abuse, emotional deprivation, and subjugation, among others. When one of these schemas is activated, the patient may become enraged and engage in behaviors such as screaming, losing control, lashing out verbally, or experiencing violent fantasies and impulses. He requires appropriate boundaries to be in place, and when these are absent, he will experience an outburst. Anger may be repressed and subsequently expressed in inappropriate ways, such as through uncontrolled venting, without consideration of the consequences for oneself and others. (Young, J. et al., 2003; Loose, Ch. et al., 2020; Brockman, RN, et al., 2023).

Angry Boy mode may manifest as a protective response to underlying vulnerabilities associated with a vulnerable child mode. In particular, if the patient has a considerable amount of energy, expressing anger may seem preferable to confronting underlying feelings of sadness (Roediger et al., 2018).
A subcategory of the angry child is the stubborn child. In this mode, the patient may experience anger yet refrain from openly displaying it. Instead, they may exhibit passive resistance to unreasonable requests or violations of their autonomy. Such behavior may be perceived by others as stubbornness (Arntz, A. et al., 2013).

Enraged Kid Mode

The Enraged Child mode is characterized by the experience of intense feelings of anger and rage, which may manifest as destructive actions towards others and/or objects. This outward display of anger is typically observed when the individual's need for assertiveness or autonomy is perceived to be undermined. The individual may perceive others as aggressors and direct their anger towards them with the intention of annihilating them, either directly or indirectly. The individual may vocalize their distress and act in an uncontrolled manner towards another person. The tone may be described as that of an enraged child who has lost control (Brockman et al., 2023; Roediger et al., 2018; Arntz et al., 2013).

While the angry child responds to perceived injustice and seeks validation, the angry child's response is accompanied by a desire to inflict physical harm (Loose, et al., 2020).

Impulsive Child Mode

The impulsive child acts in a thoughtless manner to satisfy his needs and seek pleasure without considering the limits that may be in place, the feelings of others, or the potential for negative consequences. (Young et al., 2003; Loose et al., 2020).

In the Impulsive Child mode, the patient responds to the impulses and cravings of the moment in an uncontrolled and selfish manner. They experience constant struggle to resist powerful desires and postpone gratification, as they do not tolerate limits. This can result in the patient appearing self-centred and spoiled. (Brockman et al., 2023; Roediger et al., 2018; Arntz et al., 2013).

Unruly Child Mode

The unruly child displays a lack of tolerance for frustration and an inability to delay gratification in the short term. In this mode, the patient encounters significant challenges in completing routine or uninteresting tasks. Even when faced with difficult tasks or requirements, they tend to avoid or neglect them. It is quickly relinquished, reluctantly applied, and does not persist due to its low tolerance to discomfort that is often necessary to achieve long-term goals (Young et al., 2003; Loose et al., 2020; Brockman et al., 2023; Roediger et al., 2018; Arntz et al., 2013).

A subcategory of the Undisciplined Child is the Spoiled or Selfish Child, who, in contrast to the former, is accustomed to having all of their desires fulfilled and feels entitled to do so. Consequently, the patient in this mode is inclined to be demanding and may become disillusioned if others do not meet their expectations immediately and perfectly (Loose et al., 2020; Brockman et al., 2023).

Happy Kid Mode

In Happy Child mode, the patient experiences feelings of love, value, connection to others, safety and contentment. The subject displays spontaneous sociability, cheerfulness during the game, effectiveness and resilience. He exhibits cheerful, humorous and smiling behavior. The patient experiences a sense of hope, calm, value, care, and understanding. The patient in this mode demonstrates flexibility and the capacity to adapt to the demands of the situation while maintaining alignment with their own needs. This mode is not associated with any early maladjustment schemes, as the child's fundamental needs are met in an adequate manner. The Happy Boy mode represents the absence of schema activation in a healthy state (Young et al., 2003; Loose et al., 2020; Brockman et al., 2023; Roediger et al., 2018).
The Happy Child is referenced as part of the infantile modes, yet it was not included in the present study's results, as it is not a dysfunctional schema mode.

Maladaptive coping modes

Maladaptive coping strategies represent the child's attempts to adapt to the presence of unmet emotional needs within a harmful environment. Such responses to distress are developed and reinforced over time. These coping modes were adaptive when the patient was a young child; however, they are often maladaptive in the adult world (Young et al., 2003; Loose et al., 2020).

The specific coping mode that is invoked at any given time is dependent on a number of factors, including temperament, constitution, and body condition. The objective of the coping mode is to safeguard the individual from experiencing discomfort, distress, or fear. It is selected with minimal conscious deliberation (Loose et al., 2020; Farrell et al., 2014).

These coping modes are associated with a range of behavioral reactions, which can be conceptualized on a spectrum that includes submission, withdrawal and dominance. This spectrum reflects both basic emotions (infantile modes) and appraisals (internal critical modes). The incorporation of defense mechanisms into cognitive therapy provides a valuable new perspective, facilitating a more comprehensive understanding of personality disorders for both practitioners and patients (Farrell et al., 2014; Roediger et al., 2018).

These maladaptive modes are typified by an excessive and unhealthy reliance on maladaptive coping strategies, including fight, flight, or freeze responses. In accordance with the aforementioned, three principal categories have been delineated: the Indulgent Performer, the Separate Protector, and the Overcompensator (Young et al., 2003; Farrell et al., 2014).

Surrender Modes

The term “surrender” is used to describe a coping style that involves the act of giving in or submitting to the present situation. Consequently, the individual exhibits submissive behavior as a result of apprehension regarding potential conflict or rejection. It is a means of anticipating or giving in to the perceived expectations of others, especially those considered to be the most powerful, in order to continue to be accepted (Roediger et al., 2018; Farrell et al., 2014).

Surrender can be beneficial when it is employed as a means of accepting advice and tolerating frustrations, facilitating giving and receiving, and integrating in a constructive manner. However, as with all coping mechanisms, it can become maladaptive when the level of intensity is elevated (Loose et al., 2020).

The Indulgent mode is observed in patients who were children subjected to domination or threat from paternal figures, family systems, or peer groups. Such individuals frequently present with psychosomatic symptoms, including headaches, nausea, and vomiting, as well as precursors to depression, such as intense sadness, emotional lability, sleep disturbances, and impaired performance. In severe cases, these symptoms can extend to suicidal ideation and even acts (Loose et al., 2020).

The function of the Indulgent mode is to prevent further abuse. Patients exhibiting this mode of behavior present as passive, submissive, docile, helpless, impotent, obedient, humiliated and dependent. Such individuals exhibit a tendency to refrain from resisting mockery and to subordinate themselves without hesitation. Those in this mode act in accordance with the wishes of a more powerful figure, perceiving that they have no alternative but to attempt to please this individual in order to avoid conflict and neglecting their own needs. Such individuals frequently endeavor to integrate actively, even when the associated costs are considerable. This is evidenced by their tendency to seek social contact and a sense of belonging to a group. Additionally, they may attempt to form inappropriate connections with dominant figures within a group, in an effort to gain acceptance (Young, J. et al., 2003; Loose, Ch. et al., 2020; Brockman, RN. et al., 2023; Arntz, A. et al., 2013).

Brockman et al. (2023) propose two additional subforms of the surrender mode: the Helpless Surrendered mode and the Self-Compassionate Victim mode.

In the Helpless Surrendered mode, the individual tends to idealize others, perceiving them as strong, competent, and as potential sources of assistance, capable of resolving their difficulties. In this mode, the patient may discuss their struggles and needs, but an authentic connection to vulnerability is required. They may have internalized the message that, in order to be worthy of attention, they must demonstrate their needs through others observing their helplessness, their physical vulnerability, or their frailty. This phenomenon is associated with the concept of “learned helplessness,” which emerges from childhood experiences where the individual felt dominated, helpless, overwhelmed, paralyzed by fear of rejection, abandoned, or humiliated.

In the Self-Compassionate Victim mode, the individual perceives themselves as a victim. These individuals perceive the world as being inherently unfair and believe that they have been singled out and persecuted in ways that are distinct from those experienced by others. The individual perceives others to possess power, whereas they themselves are perceived as powerless. Consequently, they are reluctant to assume responsibility for initiating change (Brockman et al., 2023).

Avoidance Modes

The avoidant coping style is characterized by a tendency to withdraw from and avoid physical, psychological and social situations.

Avoidance modes are developed in patients who, during their childhood, learned to withdraw actively or passively from situations that caused them distress, restlessness, or anxiety. These situations may be avoided by withdrawing socially or by self-soothing through activities such as eating or, particularly in younger patients, playing video games excessively (Loose et al., 2020).

Separate Protector Mode

The Separate Protector employs schema avoidance as a coping strategy. The coping style may be characterized as a form of psychological withdrawal. Those in the Separate Protective mode tend to disengage from the discomfort associated with schema activations. This is achieved by withdrawing

emotionally, which involves distancing themselves from others in order to safeguard against the distress associated with vulnerability. Such individuals tend to suppress their emotional responses, thereby rejecting external assistance and functioning in a manner that may be perceived as somewhat mechanical. Such individuals exhibit a lack of emotional responsiveness, appear emotionally distant, and avoid forming close interpersonal relationships. The disconnection from one's inner needs and thoughts is manifested in various ways, including depersonalization, feelings of emptiness, boredom, and the manifestation of psychosomatic complaints. The mode may be conceptualized as a protective barrier, akin to a wall, within which the most vulnerable modes are concealed (Young, J. et al., 2003; Roediger, E. et al., 2018; Arntz, A. et al., 2013).

The Separated Protector mode is characterized by a lack of attention or concentration during social interactions, which may manifest as brief episodes or as a more severe form of dissociation (Loose et al.). In cases where dissociation is present, a differentiated mode, the Dissociated Protector mode, has been proposed. Such individuals may continue to function in a seemingly “normal” or “autopilot” manner with regard to their daily lives, while simultaneously maintaining an emotional distance from others (Brockman et al., 2023; Farrell et al., 2014).

Some authors differentiate a subcategory of the Separate Protector, which they term the Avoidant Protector. In this mode, the individual attempts to circumvent the potential for the maladaptive schema to be activated by avoiding any situation that could evoke feelings of vulnerability. This avoidance manifests in a preference for physical distance, which is prioritized over other forms of social interaction. Therefore, social situations are eschewed, particularly those of a challenging nature, conflicts or any exciting activity, in order to avoid intense sensations (Brockman et al., 2023; Arntz et al., 2013).

Self-soothing Protector Mode (separate self-pacifier)

In Protective Self-Calming mode, the individual attempts to mitigate negative emotional states through the engagement in activities or the ingestion of substances that will induce a state of calm, stimulation, or superficial distraction. The activities in question are typically pleasurable or exciting, yet they are undertaken in an addictive or compulsive manner (Roediger et al., 2018; Arntz et al., 2013).

One may attempt to escape overwhelming emotions through solitary activities designed to self-soothe, self-stimulate, or divert attention from emotions. Such activities may include workaholism, excessive exercise, gambling, dangerous sports, promiscuous sex, internet addiction, compulsion, or drug abuse. Additionally, self-mutilating behaviors may also be employed as a means of escape. In contrast, some individuals may engage in solitary activities that are perceived to be more calming than stimulating, such as playing computer games, overeating, watching television, or fantasising excessively. The individual in question will often isolate themselves from social connections through the adoption of unconventional or distasteful behaviors (Roediger et al., 2018; Loose et al., 2020; Brockman et al., 2023).

Angry Protector Mode

Loose et al. (2020), Brockman et al. (2023) and Arntz et al. (2013) identify an avoidant mode that is not included in Young's instrument (SMI 1.1), which was updated in 2014. This was the instrument used in the present research. This mode has been designated the “Angry Protector.”

The Angry Protector mode develops in patients who, during childhood, learned to create distance from people by displaying anger. This was achieved by abusing the counterparty, other people or external circumstances, when in reality their own problems or difficulties should have been addressed. In the Angry Protector mode, the patient defends themselves through a barrier of angry hostility, driven by the assumption that others will threaten, humiliate, or embarrass them if their underlying vulnerability is revealed. However, this anger is passive and strategic in nature, as it serves to preclude any opportunity for

others to inflict harm, rejection, or exert control over the individual, thereby maintaining a safe distance. Such individuals may vocalize and complain, primarily as a means of distancing themselves from others (Loose et al., 2020; Brockman et al., 2023; Arntz et al., 2013).

Overcompensation Modes

The phenomenon of overcompensation arises as a result of the existence of an alternative to the pain associated with the aforementioned scheme. It provides a means of escape from the feelings of helplessness and vulnerability that the patient experienced during their formative years. The over compensatory coping style comprises behaviors that are in opposition to the schema or schemas that are triggered. These behaviors may be understood as acting as if the opposite of the schema were true (Young et al., 2003; Farrell et al., 2014).

Self-Enlarging Mode

In a state of self-aggrandizement, the individual experiences a sense of superiority, uniqueness, and strength, which manifests in behaviors that are authoritative, competitive, grandiose, abusive, and detached from empathy. This state is characterized by a constant pursuit of status and the attainment of desired outcomes. She is more concerned with appearances than feelings, is almost completely self-absorbed, and shows little compassion for the needs or feelings of others. The subject displays behaviors that indicate a sense of superiority, competitiveness, self-centeredness, and a tendency to seek admiration and self-aggrandizement. Additionally, the subject exhibits expectations of special treatment and a lack of adherence to the rules and norms that apply to the general population (Roediger et al., 2018; Loose et al., 2020; Brockman et al., 2023; Arntz et al., 2013).

Bully-Attack Mode

The phenomenon of bullying and attack can be defined as follows: In this mode of operation, the perpetrator employs a range of tactics, including threats, intimidation, aggression, and coercion, to achieve their desired outcome. This may involve inflicting harm on others in a calculated and strategic manner, whether emotional, physical, sexual, verbal, or through the use of antisocial methods or criminal acts. In this mode, the individual subjects others to ridicule and humiliation, launching verbal or physical attacks in an attempt to evoke a similar pain response as that which they themselves experienced in the past. They initiate attacks in anticipation of future attacks from others. The objective is to establish a dominant position through the use of intimidation. The motivation may be to compensate for or prevent abuse or humiliation (Roediger, E. et al., 2018; Loose, Ch. et al., 2020; Brockman, RN). (Et al., 2023; Arntz, A. et al., 2013).

In their 2018 study, Roediger and colleagues differentiate avoidant coping into two forms: a more passive and an active form. They propose four main coping styles, which they represent by maladaptive coping modes on a dimensional spectrum. This spectrum ranges from complacent surrender (surrender) to overcompensating (fighting). The four main coping styles are as follows:

1. Detached protective (freezing/passive avoidance)

2. Independent self-soothing (flight/active avoidance)

In addition to the modes, included by Young in SMI 1.1, other overcompensating modes with specific nuances have been proposed:

Scammer-Manipulator Mode

In a state of scam mode, the patient engages in deceitful and manipulative behavior, including plotting against others, seeking retribution, and exploiting others as pawns in a game. He also engages in self-promotion and presents himself in a positive light. The individual in question will resort to the manipulation,

deceit and victimization of others in order to achieve their own goals. Furthermore, they may attempt to exploit others and subsequently attempt to evade the negative consequences of their actions. This mode is frequently observed in criminal behavior, but it is also evident in some narcissistic individuals, who utilize deception and manipulation to achieve their desired outcomes (Loose et al., 2020; Brockman et al., 2023; Arntz et al., 2013).

Predator Mode

In the Predator mode, the individual attempts to inflict harm and, in some cases, even cause death. This mode is characteristic of individuals with psychopathic and antisocial personality traits. The individual engages in strategic planning and maneuvering with a detached and indifferent approach, targeting those who may pose a potential threat, enemy, competitor, or obstacle (Loose et al., 2020; Brockman et al., 2023).

Arntz et al. (2013) highlight that the individual in this mode focuses on neutralizing a threat, rival, obstacle or enemy in a detached, unemotional and calculated manner. In contrast to the intimidation and attack mode, which is characterized by "hot" aggression, the predator mode is typified by cold, ruthless aggression, a trait that is predominantly observed in individuals with psychopathic tendencies.

Attention Seeking Mode

In this mode, the individual seeks attention and acceptance through exaggerated emotional displays, which may manifest in flirtatious or sexualized ways. The underlying message, however, is often superficial and theatrical. Such individuals attempt to impress others through ostentatious, extravagant, or theatrical behaviors in order to overcome underlying feelings of loneliness or the perception of being overlooked (Loose et al., 2020; Brockman et al., 2023; Arntz et al., 2013).

Over-control modes

Brockman et al. (2023) and Arntz et al. (2013) posit that an individual exhibiting one of the modes of excess control strives to attain a sense of control through reflection, exhaustive analysis, ritualized behavior, meticulous planning, or obsession. The individual may exhibit a pronounced focus on productivity and time management in order to attain a sense of accomplishment or value and to overcome an underlying sense of helplessness or failure. In order to reduce uncertainty, unpredictability, and vulnerability to potential harm, they attempt to pay excessive attention to detail and rigidly follow the rules.

A number of subtypes have been identified. The Excessive Controller mode is characterized by the individual is inclined to subject every detail to scrutiny, regardless of whether an error has been committed. This inclination is accompanied by a sense of responsibility for all tasks and a tendency to express dissatisfaction with the volume of work and the state of the work environment (Loose et al., 2020).

The Perfectionist Excessive Controller mode can be defined as follows: The individual attempts to safeguard themselves from perceived or actual threats, including criticism, mistakes, harm, or blame, through a heightened level of awareness, resulting in significant pressure and a tendency to focus on consistently performing tasks correctly and avoiding mistakes to minimize the likelihood of criticism, disappointment, and failure (Loose et al., 2020; Brockman et al., 2023).

Brockman et al. (2023) identify the following subtypes:

The Suspicious Overcontrol Mode The patient displays heightened levels of vigilance, caution, and distrust of the motives of others. The individual may exert control over others in order to safeguard against perceived threats and persecutory behaviours.
Overanalyze mode is characterized by the predominance of verbal-linguistic processing of material oriented to the past and/or the future (e.g. rumination, worry, or obsessive thinking), at the expense of attending to the contextual and emotional qualities of the present and the experience of the moment.

Furthermore, they suggest the inclusion of the following:
Excessive Controller Mode characterized by scolding. The individual attempts to exert control over others through the use of blame, criticism, scolding, and/or authoritarian guidance. This is referred to as the Flagellant Overcontroller Mode. An individual may engage in self-punishment and self-blame as a means of compensating for a fear of attack or punishment, with the objective of reinstating a sense of control. Furthermore, self-punishment or deprivation may serve as an attempt at self-improvement, appeasement, reduction of the risk of being humiliated or punished (either by others or by one's own inner critic), increase in perceived control over suffering and pain, or atonement for unresolved guilt or shame.
The Invincible Overcontroller (Hyper-Autonomous) mode is characterized by: In this mode, the individual experiences a sense of invincibility, indestructibility, and power. In this mode, the individual strives to achieve complete invulnerability and to negate or transcend their emotional needs by behaving in a self-sufficient manner that precludes the necessity for emotional connection with others.
Similarly, Arntz, A. et al. (2013) put forth the concept of the Paranoid Excessive Controller mode, in which the individual focuses on monitoring and scrutinizing others for indications of malevolence, thereby exerting control over their behavior through suspicion.

Internal Critical Modes (formerly Dysfunctional Parental Modes)

As posited by Young, J. et al. (2003), dysfunctional paternal modes may be understood as internalization of father figures experienced during the patient's formative years. When patients are in a dysfunctional parent mode, they engage in self-parenting behaviors, mirroring the parenting styles they experienced during their upbringing. Such individuals frequently adopt the voice of their parents in their internal monologue. In dysfunctional parenting modes, patients exhibit cognitive, emotional, and behavioral patterns reminiscent of those exhibited by their parents towards them during their childhood. Consequently, childhood internalization encompass messages from experienced parents as non-psychotic “voices in the head” (Roediger, E. et al., 2018; Young, J. et al., 2003).

However, as Loose, Ch., et al. (2020) observe, the term 'parent mode' may be a misnomer, as experiences with peers and significant others, such as school teachers or coaches, can also be a key part of these modes. For this reason, these modes have also been designated as 'internal critical modes'. Similarly, Farrell, J. et al. (2018) and Roediger, E. et al. (2018) concur that referring to these modes as “internal critics” is more convenient and useful than “parental modes,” as clients often associate the term “father” with images of their actual parents, which can lead to loyalty conflicts. The term “inner critic” is indicative of the presence of internalized dysfunctional beliefs, as opposed to memories of actual parents, which are often more complex and ambivalent.

The beliefs that a client may have internalized may not have been explicitly expressed; however, they could be the result of the child's mentalization activities. This reflects the selective internalization of negative aspects of attachment figures during childhood and adolescence (Roediger, E. et al., 2018).

Upon entering these modes, the patient becomes subject to the internalized voice of parents or other educators, which is characterized by criticism and punishment. This results in feelings of self-reproach and the conviction that they are deserving of punishment for experiencing and/or expressing normal needs that were punished during childhood. The tone is therefore characterized by harsh, critical and unforgiving language. The presence of self-loathing, self-criticism, self-denial, self-harm, suicidal ideation, and self-destructive behavior are indicative of this condition (Arntz, A. et al., 2013).

Critical Mode (Parent) Punitive

A punitive parent is one who punishes, criticizes or restricts a child in a state of anger when the child expresses their needs or makes mistakes. In this mode, patients act as punitive parents, punishing the vulnerable child. This is characterized by attacks on the child's identity, belittling and undermining their self-esteem, and even questioning their right to exist (Loose, C. et al., 2020; Young, J. et al., 2003).

This mode conveys the belief that vulnerability, needs, and emotions are indications of weakness and should be punished or eradicated. The individual in this mode may experience repeated reenactments of previous experiences of guilt, criticism, punishment, or deprivation (Brockman, RN et al., 2023).

Critical (Parent) Demanding or Demanding Mode

The demanding parent exerts pressure on the child to achieve expectations that are excessively high. The individual in question considers it their duty to strive for perfection, whereas any display of fallibility or spontaneity is regarded as a misstep. Those who adopt a demanding parenting style set high standards for themselves and strive to meet them (Young et al., 2003).

The punitive parent can be distinguished from other types of parents by their greater focus on achievement and/or their higher levels of emotional demand. Such a condition may manifest when a child is placed in a situation where they are expected to meet standards of care that are not developmentally appropriate, particularly in relation to the care of siblings, other individuals, or even their parents (Loose et al., 2020).

In this mode, the patient exerts himself excessively in order to reach a very high level of performance, maintain control over his environment, achieve a high status or be efficient, and avoid wasting time. He attempts to retain total control over himself and the expression of his emotions or needs. These demands can be directed at oneself and others (Roediger et al., 2018; Brockman et al., 2023; Arntz et al., 2013).

In addition to the aforementioned modes, recent updates have proposed the following critical modes:

Guilt-Inducing Critical Mode: Those who are in a state of Guilt-Inducing Critical Mode experience thoughts that convey the message that the needs of others are of greater importance or urgency than their own, and that they are a burden and do not deserve attention. Furthermore, the individual may have internalized the message that the expression of their needs and emotions is selfish, potentially harmful, or a threat to others and should be suppressed at all costs (Brockman, RN. et al., 2023).

Anxious Critical Mode: Typically, this mode includes anxious messages and concerns about potential negative outcomes. Such messages damage the patient's needs for autonomy and performance, as they convey a sense of overprotection and intrusion, and fail to allow for independence. Such individuals tend to magnify the perceived danger through the use of messages such as “you will get sick” or “something terrible will happen” (Peled, O., 2016, cited in Morales, S., 2023).

The permissive critical mode is characterized by the transmission of permissive messages that promote the prioritization of pleasure and desires without restrictions or consideration of the consequences of the environment. This mode of communication is typified by the transmission of messages that are permissive in nature. These messages tend to promote the prioritization of pleasure and desires without any restrictions or consideration of the consequences of the environment. Such messages impede the capacity to establish realistic boundaries, as they facilitate procrastination, which can ultimately result in substantial ramifications due to a dearth of discipline. In instances where an individual fails to fulfil their obligations, they frequently ascribe blame or experience regret when confronted with the adverse consequences in their external environment (Peled, O., 2016, cited in Morales, S., 2023).

RESULTS

The following is an analysis of the results of the Inventory of Schema Modes (SMI 1.1), created by Jeffrey Young, applied to 47 subjects, 33 women and 14 men, aged between 19 and 58 years, users of a psychological care center coordinated by the University of Veracruzana, a public institution located in the City of Poza Rica. The location is Veracruz, Mexico.

The pie charts illustrate the frequency and percentage distribution of each coping mode across the various response categories. The categories are defined as follows: very low, average, moderate, high, very high,

and severe. Furthermore, the bar graphs present the frequencies of these categories obtained proportionally for men and women.

The results are presented in a manner that groups together the innate infant modes or child modes, the dysfunctional coping modes of surrender, avoidance and overcompensation, the critical modes and the healthy modes. The comparative information between men and women was organized in a way that allows for the visualization of the behaviors in which both groups differ the most, and those in which they differ the least, from left to right.

In the category of Child Modes, all modes are presented, with the exception of the Happy Child, which is presented in the category of Healthy Modes.

Innate Modes Infants (Child Modes)

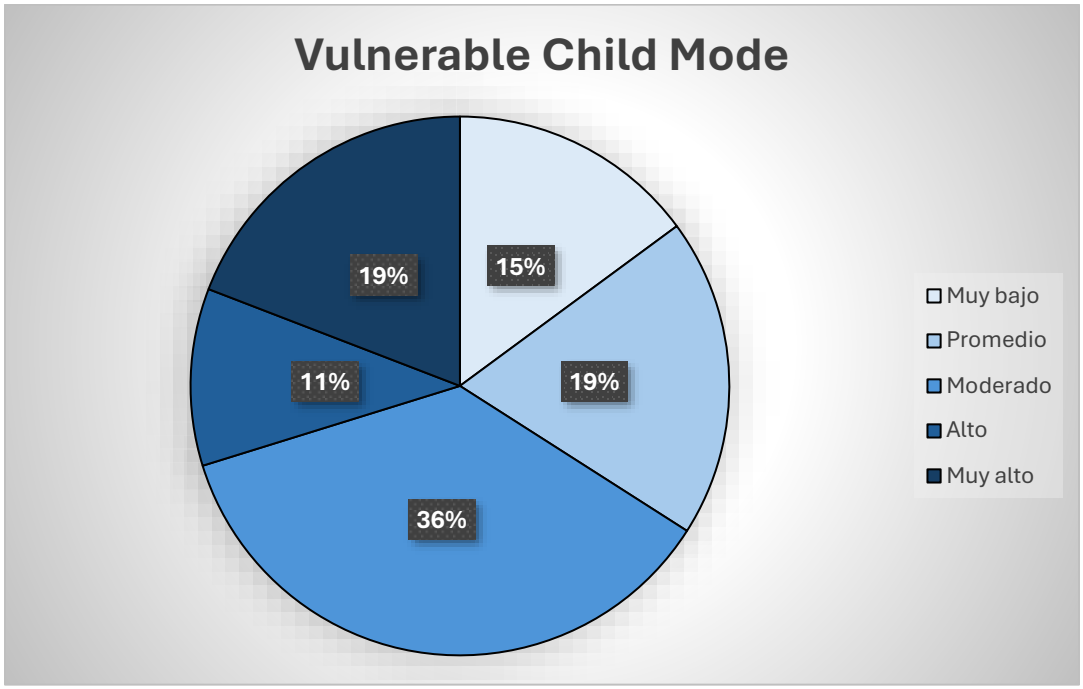


Figure 1.1 Percentage of frequencies of the different severity categories for the Vulnerable Child Mode, in the total number of subjects.

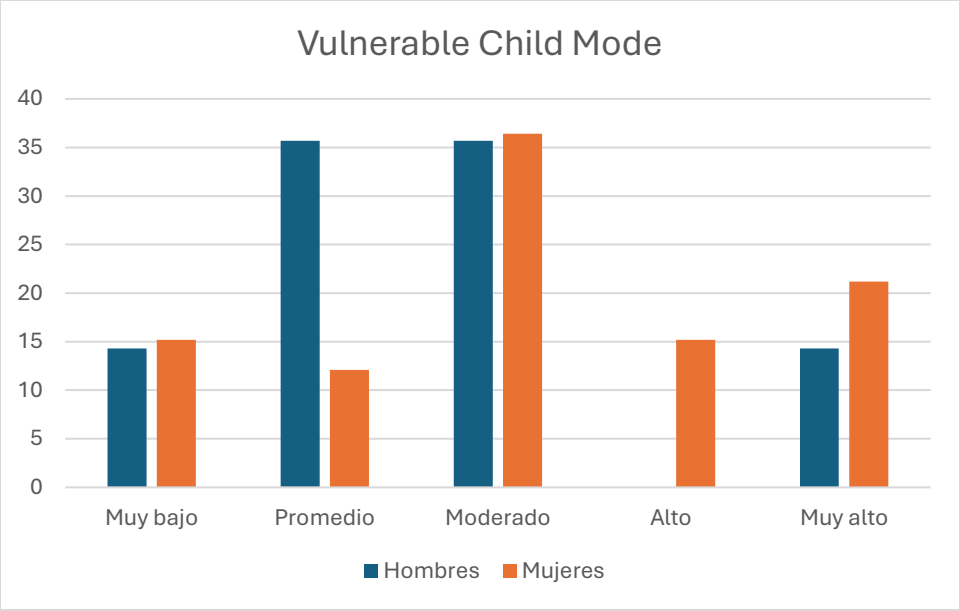


Figure 1.2. Proportions of frequency of response in men and women, in the different categories of severity of the Vulnerable Child mode.

It can be observed that 30% of the users exhibited scores indicative of vulnerability in the "Child" mode, while 66% also demonstrated scores within the "Moderate" category. This latter mode was the fourth most prevalent among the total population under study. In the comparative analysis, women exhibited a higher frequency of responses within the High and Very High categories, while both populations demonstrated comparable frequencies within the Moderate category.

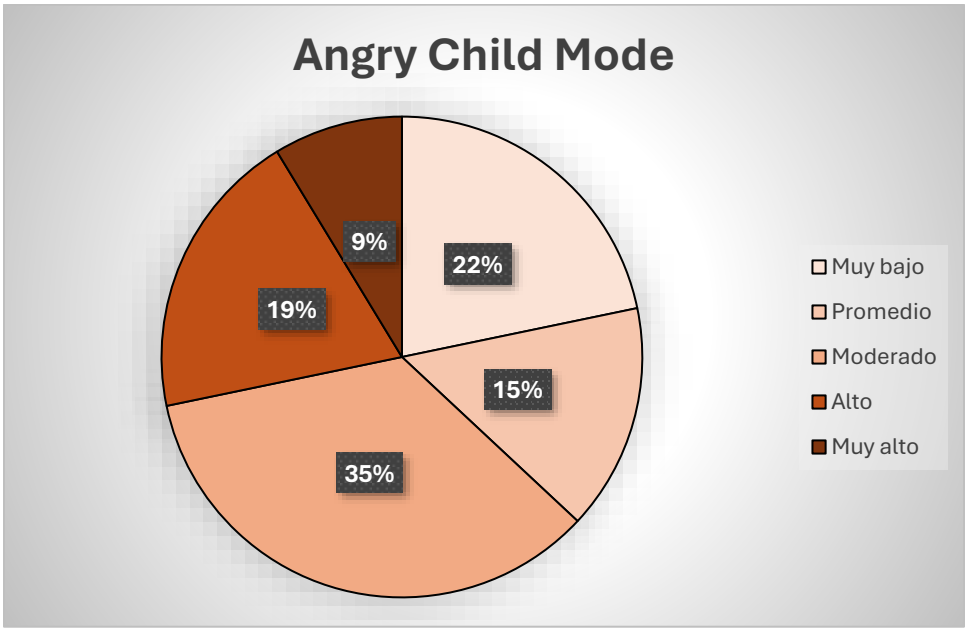


Figure 2.1. Percentage of frequencies of the different severity categories for the Angry Child Mode, in the total population studied.

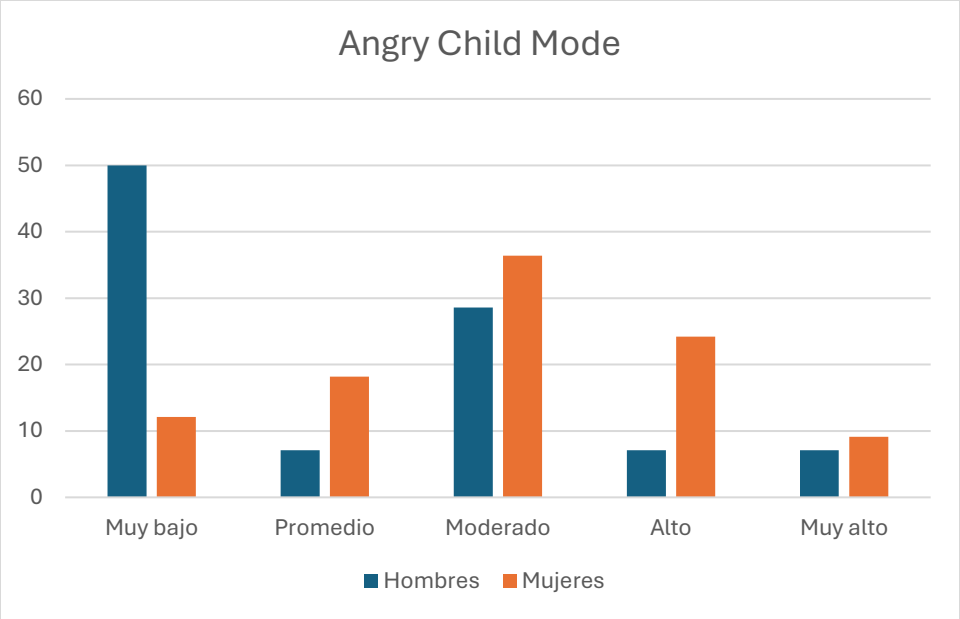


Figure 2.2. Proportions of frequency of response in men and women, in the different categories of severity of the Angry Child mode.

A total of 28% of users exhibited high or very high scores in the Angry Child mode, while 63% also demonstrated moderate scores, representing the seventh and fifth most prevalent modes, respectively, within the studied population. In the comparative analysis, female subjects exhibited higher frequencies in the Moderate, High, and Very High categories.

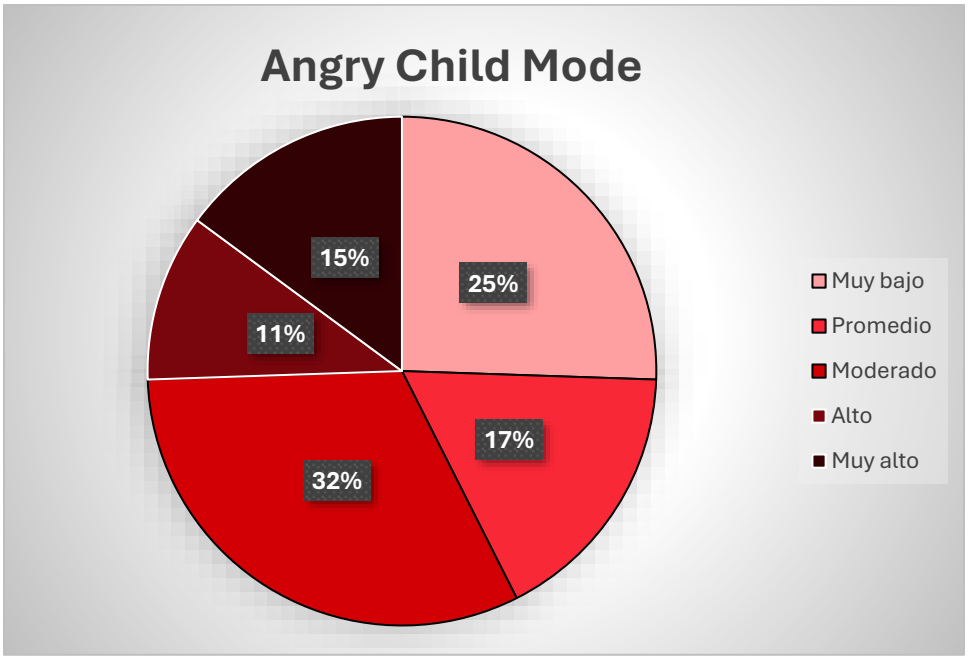


Figure 3.1 Percentage of frequencies of the different severity categories for Enraged Child Mode, in the total population studied.

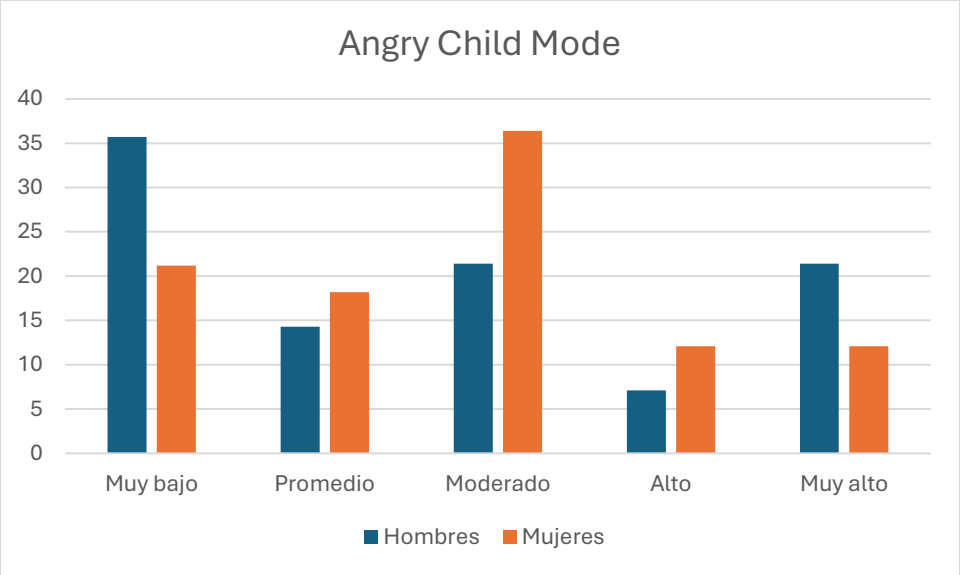


Figure 3.2. Proportions of frequency of response in men and women, in the different categories of severity of the Enraged Child mode.

Figure 2.2. illustrates that 26% of users exhibited high and very high scores in the Enraged Child mode, while 58% also demonstrated moderate scores, representing the third and seventh most prevalent modes, respectively, within the total population under study. In the comparative analysis, males exhibited a higher frequency of responses within the Very High category, whereas females demonstrated a higher frequency of responses within the Moderate and High categories.

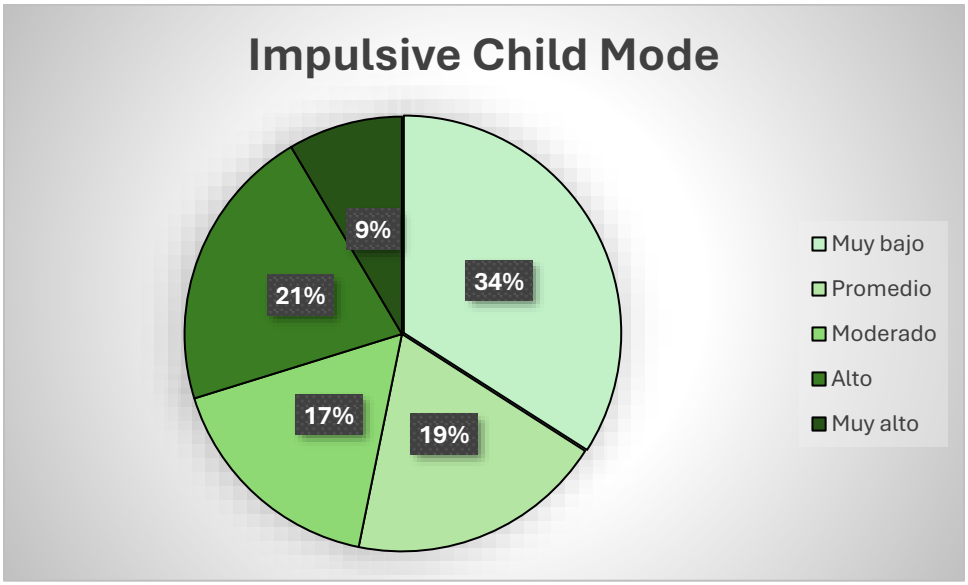


Figure 4.1 Percentage of frequencies of the different severity categories for Impulsive Child Mode, in the total population studied.

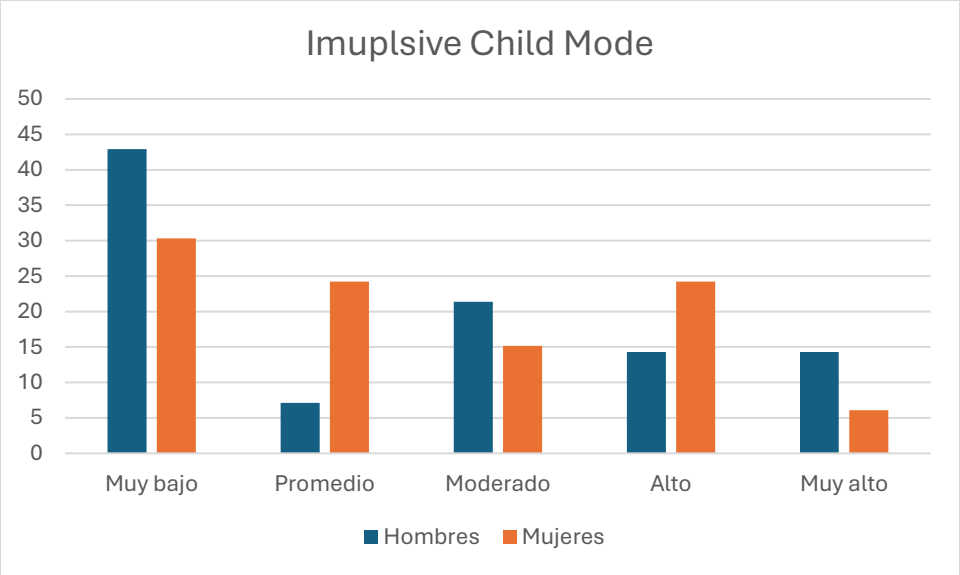


Figure 4.2. Proportions of frequency of response in men and women, in the different categories of severity of the Impulsive Child mode.

The results indicated that 30% of the users exhibited high and very high scores in the Impulsive Child mode, while 47% also demonstrated moderate scores, representing the fifth and ninth modes, respectively, that were most prevalent in the total population under study. In the comparative analysis, males exhibited higher frequencies in the Very High and Moderate categories, whereas females demonstrated higher frequencies in the High category.

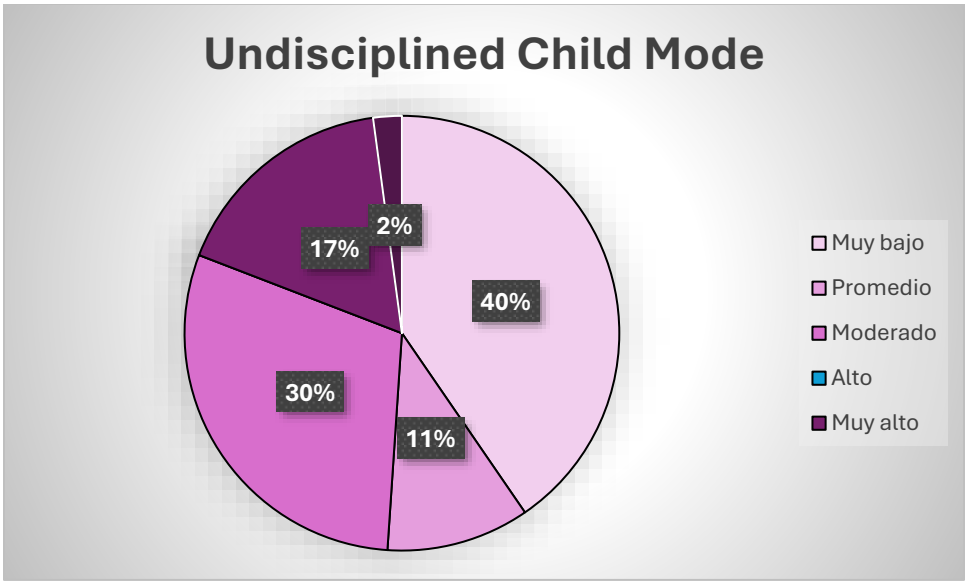


Figure 5.1 Percentage of frequencies of the different severity categories for Undisciplined Child Mode, in the total population studied.

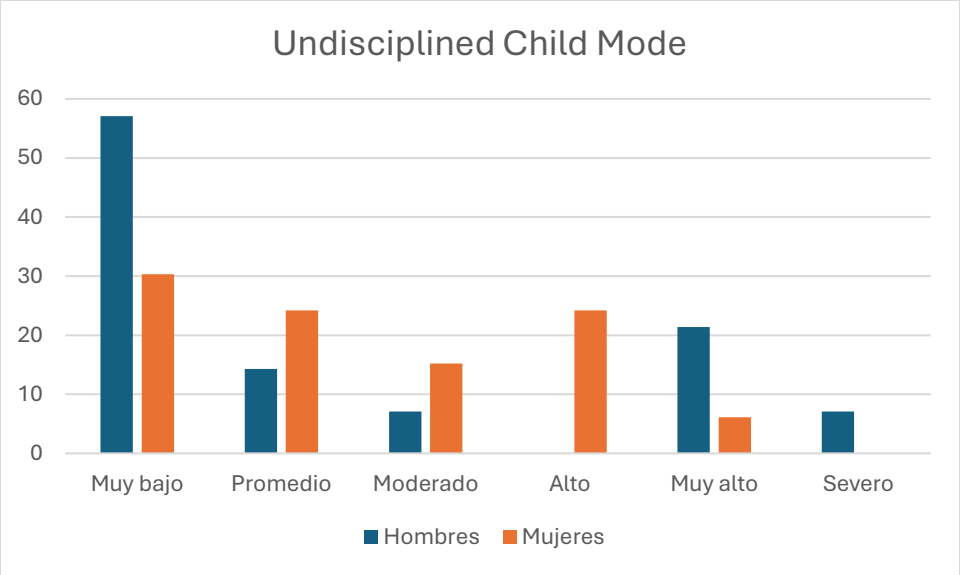


Figure 5.2. Proportions of frequency of response in men and women, in the different categories of severity of the Undisciplined Child mode.

A total of 19% of the users exhibited high and very high scores in the Impulsive Child mode, while 49% also demonstrated moderate scores, representing the fifth and eighth most prevalent modes, respectively, within the total population under study. In the comparative analysis, males exhibited higher frequencies in the Very High and Severe categories, whereas females demonstrated higher frequencies in the High category.

Adaptive Coping Modes of Surrender and Avoidance

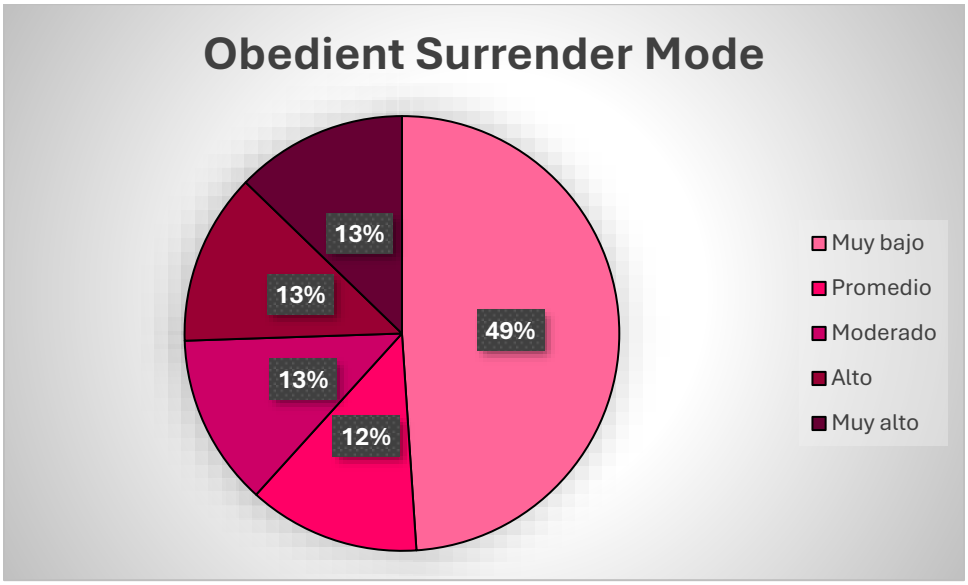


Figure 6.1. Percentage of frequencies of the different severity categories for the Obedient Surrender Mode, in the total population studied.

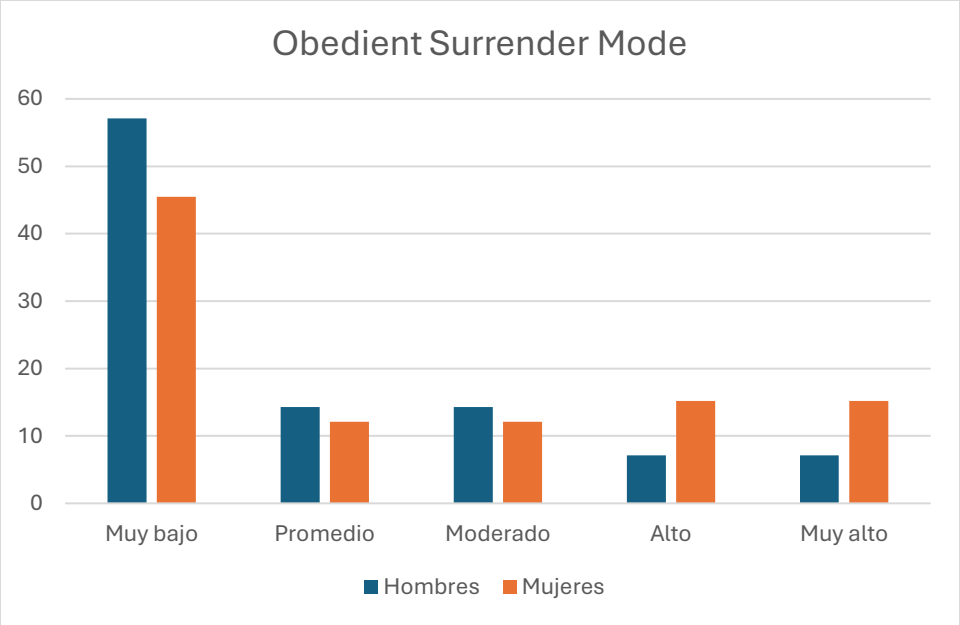


Figure 6.2. Proportions of frequency of response in men and women, in the different categories of severity of the Obedient Surrender mode.

It can be observed that 29% of the users exhibited high and very high scores in the Obedient Surrender mode, while 39% also demonstrated moderate scores, representing the sixth and eleventh modes, respectively, that were the most prevalent in the total population under study. In the comparative analysis, women exhibited a higher frequency of responses within the Very High and High categories, whereas men demonstrated a higher frequency within the Moderate category.

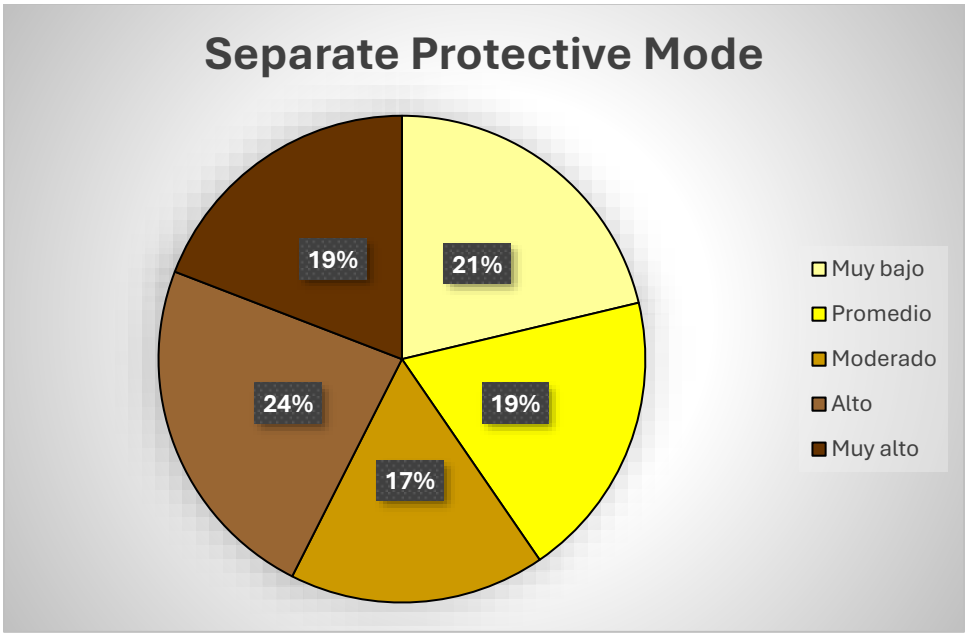


Figure 7.1 Percentage of frequencies of the different severity categories for the Separate Protective Mode, in the total population studied.

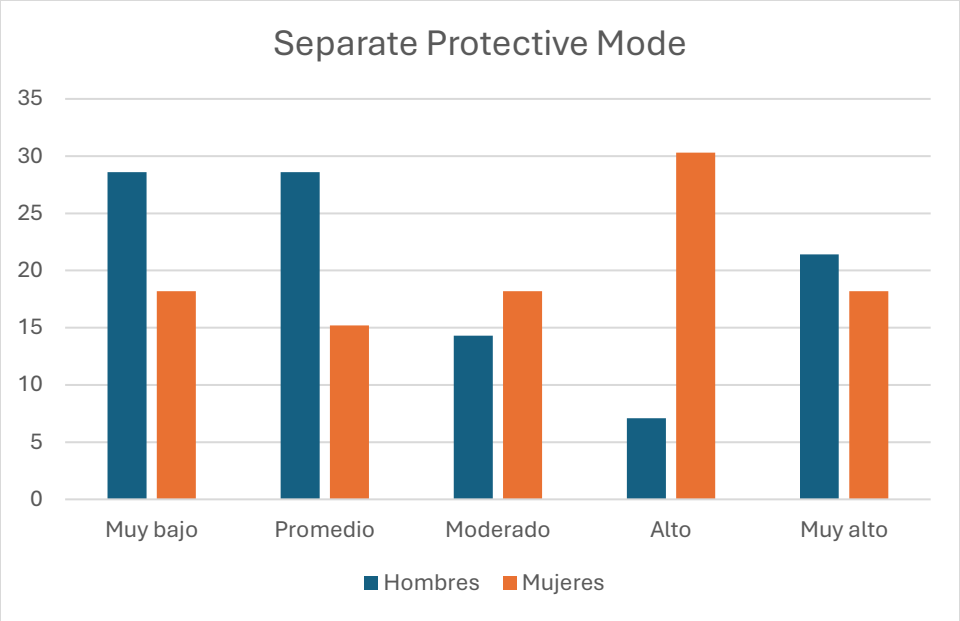


Figure 7.2. Proportions of frequency of response in men and women, in the different categories of severity of the Separate Protector mode.

It was observed that 43% of the users scored in the High and Very High categories in the Separate Protector mode, and 60% also scored in the Moderate category, which was the second and sixth most prevalent mode, respectively, in the population under study. In the comparative analysis, males exhibited a higher frequency of responses within the Very High category, whereas females demonstrated a higher frequency of responses within the High and Moderate categories.

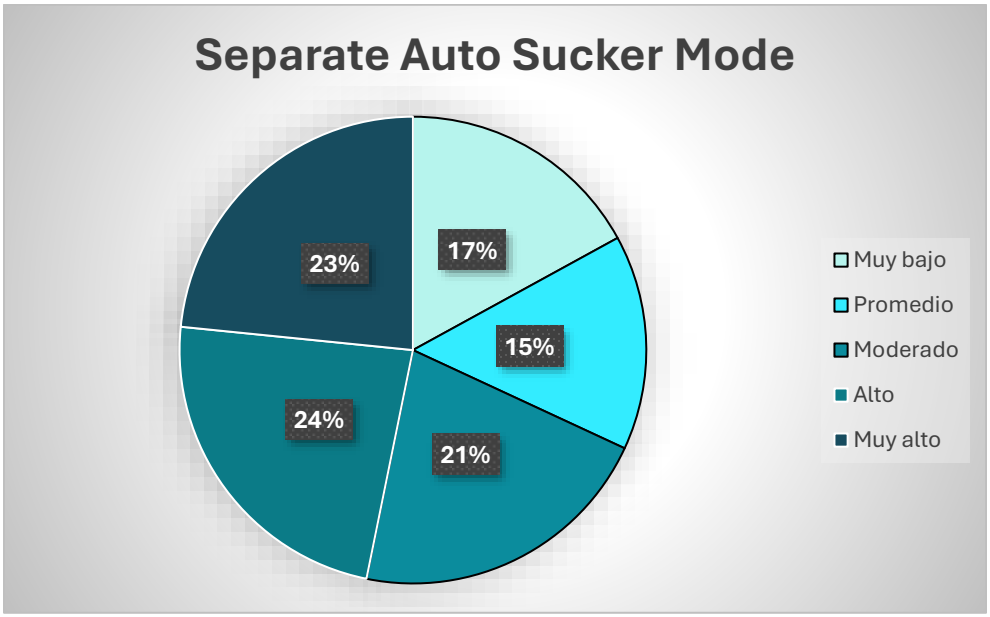


Figure 8.1 Percentage of frequencies of the different severity categories for the Separate Self-Pacifier Mode, in the total population studied.

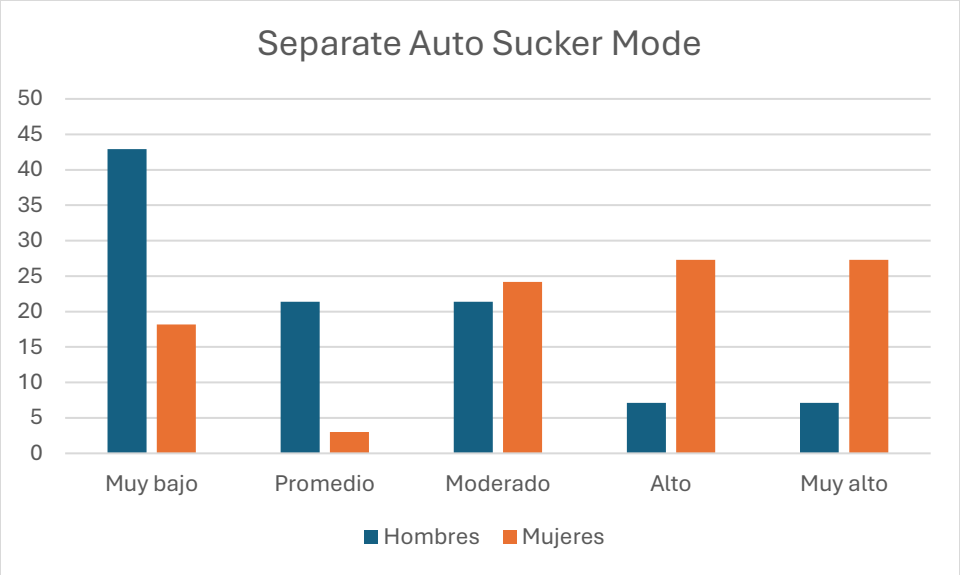


Figure 8.2. Proportions of frequency of response in men and women, in the different severity categories of the Separate Self-Pacifier mode.

The graph illustrates that 47% of users exhibited high and very high scores in the separate self-pacifier mode, while 68% also demonstrated moderate scores, representing the first and third modes, respectively, that were most prevalent in the studied population. In the comparative analysis, female subjects exhibited higher frequencies in the Very High, High, and Moderate categories.

Dysfunctional Coping Modes of Overcompensation

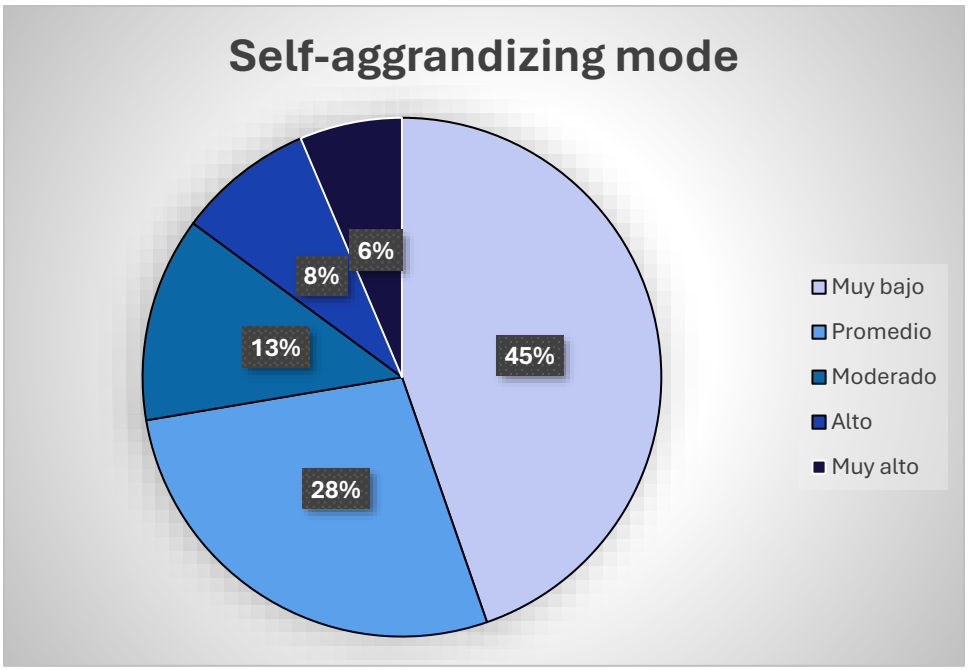


Figure 9.1 Percentage of frequencies of the different severity categories for the Self-Enlargement Mode in the total population studied.

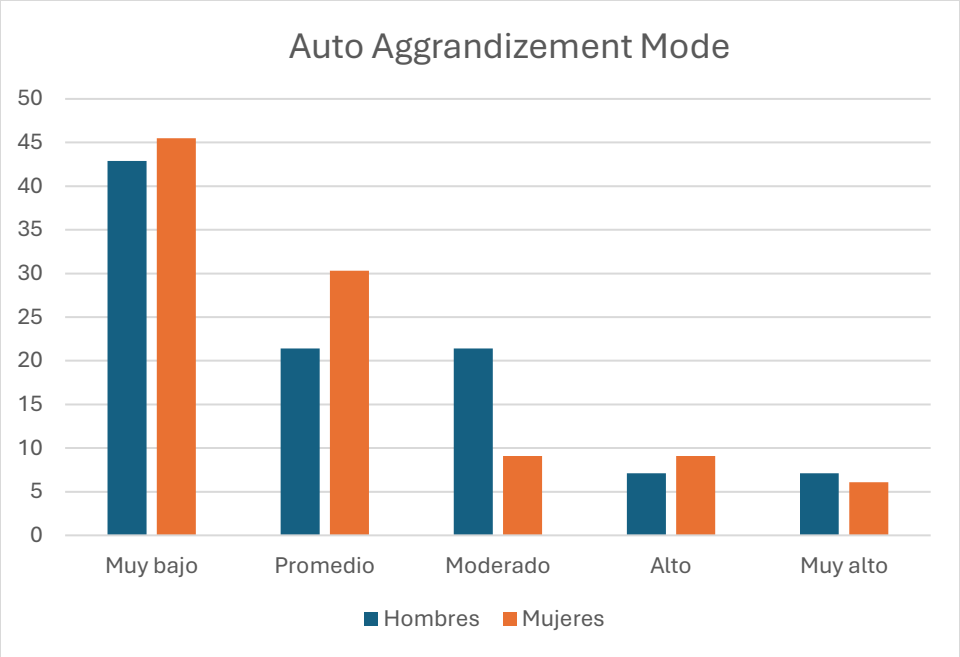


Figure 9.2. Proportions of frequency of response in men and women, in the different categories of severity of the Self-Enlargement mode.

The results indicated that 14% of the users exhibited high and very high scores in the self-enhancement mode, while 27% also demonstrated moderate scores, representing the 11th and 14th most prevalent modes, respectively, within the total population under study. In the comparative analysis, males exhibited higher frequencies in the Very High and Moderate categories, whereas females demonstrated higher frequencies in the High category.

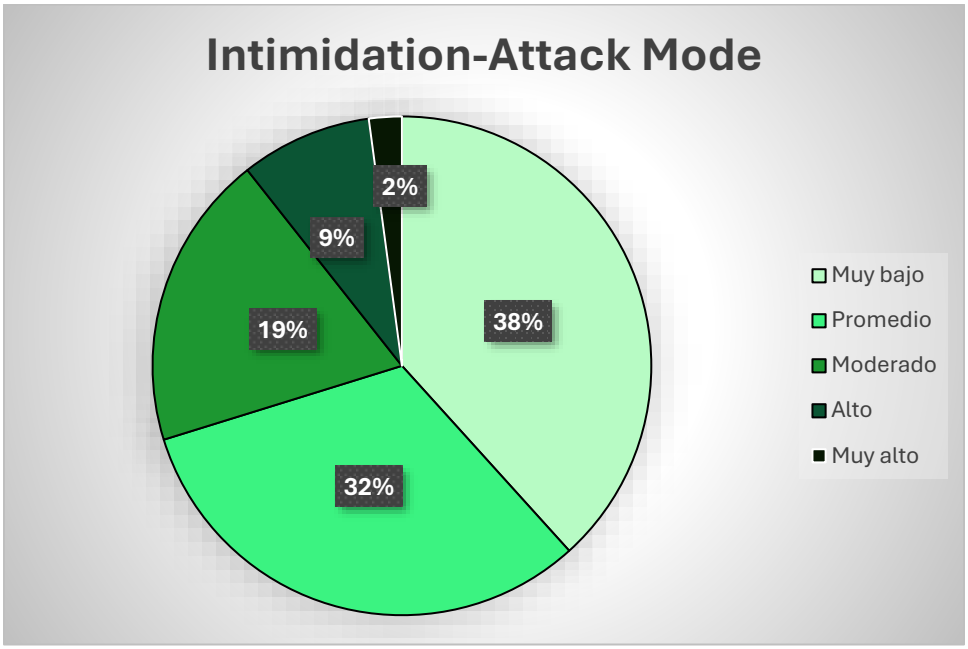


Figure 10.1. Percentage of frequencies of the different severity categories for the Intimidation-Attack Mode, in the total population studied.

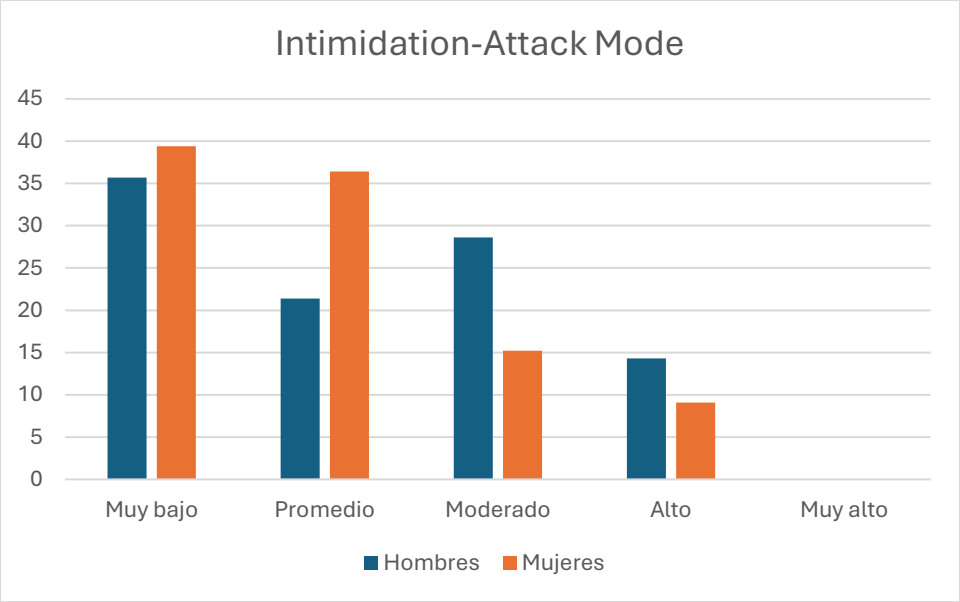


Figure 10.2.- Proportions of frequency of response in men and women, in the different categories of severity of the Intimidation-Attack mode.

A total of 11% of users exhibited high or very high scores in the Intimidation-Attack mode, while 30% also demonstrated moderate scores, representing the 10th most prevalent mode in the total population under study. In the comparative analysis, males exhibited a higher prevalence in the High and Moderate categories.

Critical Modes (Parental)

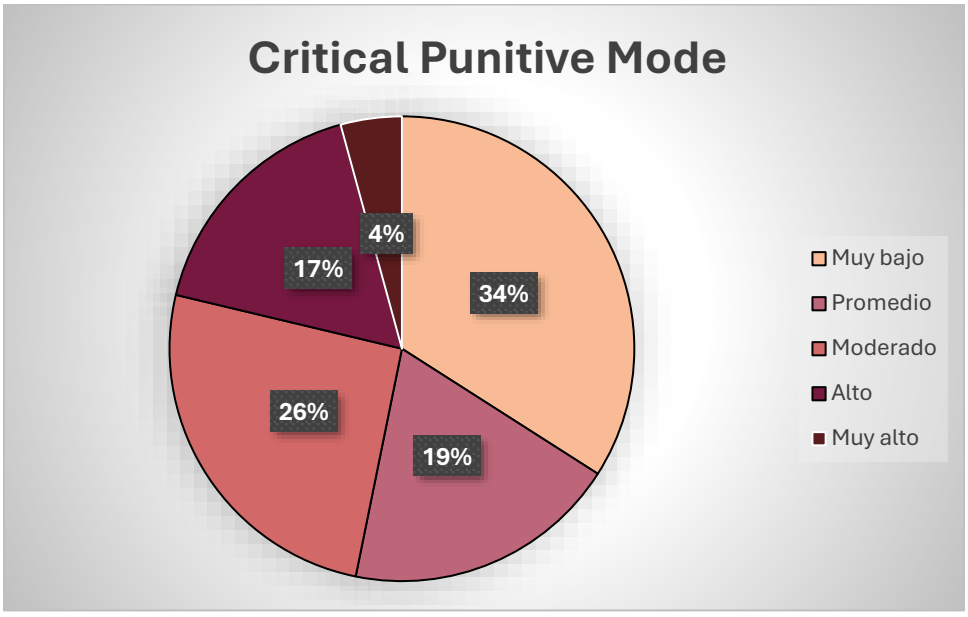


Figure 11.1 Percentage of frequencies of the different severity categories for the Punitive Critical Mode, in the total population studied.

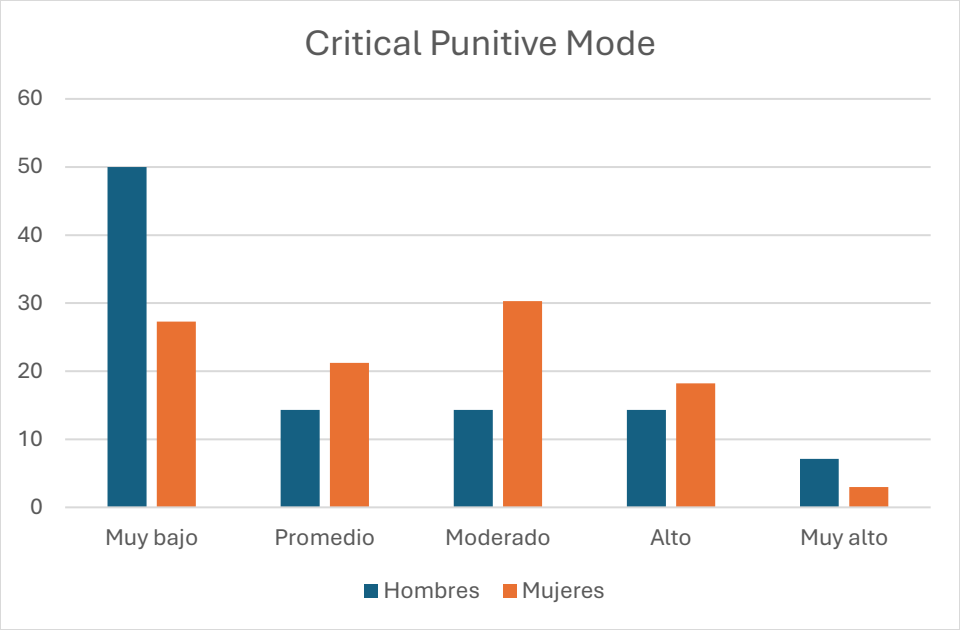


Figure 11.2. Proportions of frequency of response in men and women, in the different categories of severity of the Critical Punitive mode.

It can be observed that 21% of the users exhibited high and very high scores in the Punitive Critical mode, while 47% also demonstrated moderate scores, representing the ninth and tenth modes, respectively, and the most prevalent in the total population under study. In the comparative analysis, males exhibited a higher frequency of responses within the Very High category, whereas females demonstrated a higher frequency of responses within the Moderate and High categories.

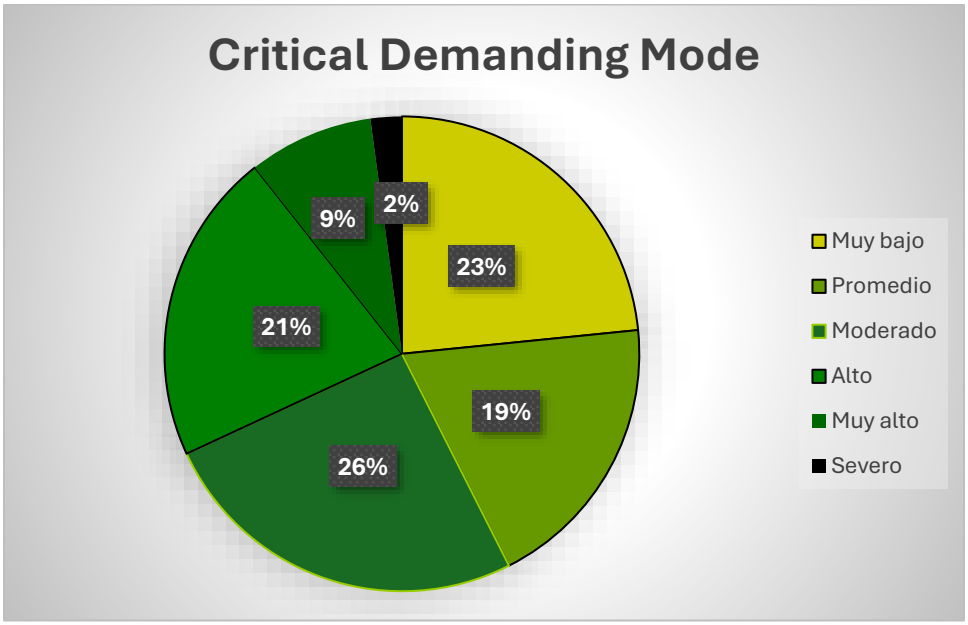


Figure 12.1 Percentage of frequencies of the different severity categories for the Critical Demanding Mode, in the total population studied.

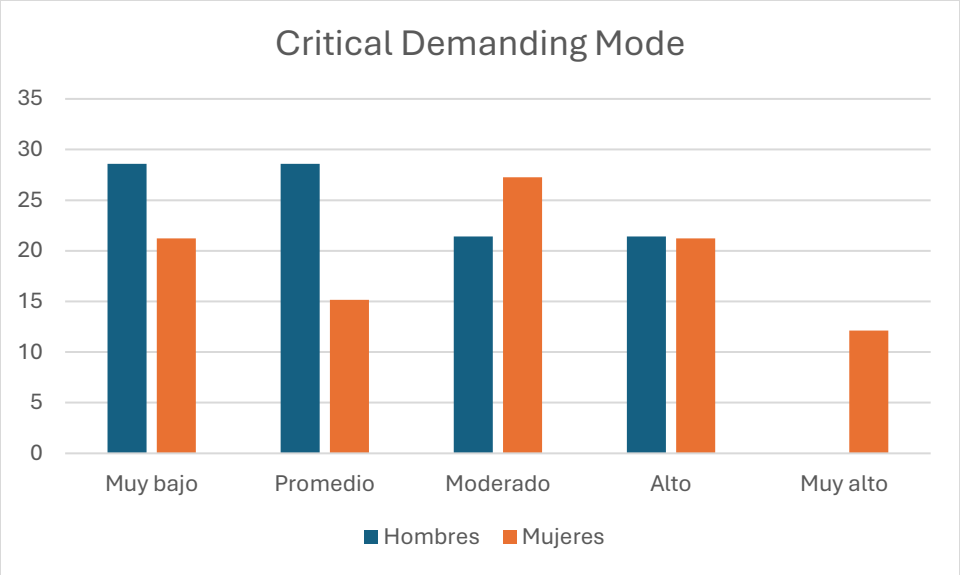


Figure 12.2. Proportions of frequency of response in men and women, in the different categories of severity of the Critical Demanding mode.

It was observed that 11% of the users exhibited high and very high scores in the critical demanding mode, while 32% also demonstrated moderate scores, representing the 14th and 12th most prevalent modes, respectively, within the total population under study. In the comparative analysis, women exhibited higher frequencies in the Very High and Moderate categories, while both populations demonstrated comparable frequencies in the High category.

CONCLUSIONS

A dysfunctional schema mode is characterized by the emergence of maladaptive schemas or coping responses that give rise to distressing emotions, avoidance behaviors, or self-defeating actions that exert control over an individual's functioning (Young et al., 2013).

Infantile modes are innate expressions of emotion and behavior that emerge prior to any parenting experience. These modes are characterized by a high level of emotional intensity and typically manifest as primary emotions.

The results of the study indicate that, in terms of the Innate Infant Modes or Child Modes, women exhibited higher frequencies in the Vulnerable Child mode. This suggests that, in general, they experience a greater sense of overwhelm, along with heightened levels of sadness, helplessness, anxiety, shame, and guilt. Furthermore, they are more prone to feelings of emptiness, loneliness, unacceptability, and a sense of unworthiness in the eyes of others. Additionally, higher frequencies were observed in the Angry Child mode, indicating that the participants perceived a lack of fulfilment of their emotional needs and perceived unfair treatment. It can be reasonably deduced that women in this demographic are more prone to experiencing feelings of anger, rage, frustration, impatience, and indignation. These emotions may be alternately repressed and then expressed in inappropriate ways, such as outbursts of uncontrolled venting.

Conversely, the male subjects exhibited slightly higher frequencies in the Enraged Child, Impulsive Child, and Undisciplined Child modes. This suggests that, in addition to experiencing anger regarding the unmet physical or emotional needs, they may also display a proclivity for inflicting physical harm. Furthermore, they may engage in impulsive or thoughtless actions to attain satisfaction, without consideration for others or potential adverse consequences. They are more likely to avoid routine or tedious tasks, give up easily, apply themselves reluctantly, or not persevere in challenging requirements.

Maladaptive coping modes represent attempts to adapt to the presence of unmet emotional needs within a context that is harmful. These responses to distress are developed and reinforced over time. They can be classified into three categories: modes of surrender, avoidance, and overcompensation. These coping modes are designed to shield the individual from experiencing pain, anxiety, or fear.

With regard to maladaptive coping modes, women were more likely to exhibit the Obedient Surrender mode, which suggests that they are more inclined to acquiesce to external demands, adopt a passive and dependent role, comply with the wishes of others, and experience feelings of helplessness in the presence of a more powerful figure. They may perceive that they have no alternative but to attempt to please others to avoid conflict.

Additionally, they exhibit a higher frequency of the Separate Protector and Separate Self-Pacifier modes, indicating a proclivity towards passive avoidance, emotional emptiness, and behavioral manifestations such as physical, psychological, and social withdrawal, emotional suppression, refusal of assistance, disconnection from others and from their own emotions, needs, and internal thoughts. Furthermore, they engage in active avoidance behaviors. Such individuals may consume substances that have a calming, stimulating or distracting effect, or engage in activities that are generally perceived as pleasurable or exciting. However, this may occur in an addictive or compulsive manner, as evidenced by excessive work or exercise, internet addiction, or self-mutilating behaviors, among other examples.

Conversely, male subjects exhibited higher frequencies in the modes of overcompensation, both in Self-Enlargement and in Intimidation-Attack. This indicates that they are more likely to exhibit behaviors such as feeling superior, special and powerful, and behaving in an authoritative, competitive, grandiose or abusive manner to achieve their desired outcomes. They may also display a greater propensity for domination and control and demonstrate less compassion for the needs and feelings of others. Additionally, they may be more inclined to utilize threats, intimidation, aggression, coercion, retaliation and harm towards others in a calculated and strategic manner, thereby asserting a dominant position.

Dysfunctional critical (parental) modes reflect the selective internalization of negative aspects of attachment figures (e.g. parents, teachers, peers, etc.) during childhood and adolescence. Such individuals internalize “voices” that condemn and punish them, leading to feelings of self-reproach for having normal needs that were suppressed during childhood.

In the domain of critical modes, it is observed that in the population under study, there are comparable frequencies between men and women in the Punitive Critic. This indicates that both groups exhibit analogous tendencies with regard to the conviction that vulnerability, needs and emotions are indications of weakness and should be punished. Furthermore, these tendencies manifest in comparable forms, such as the manifestation of signs and symptoms of self-loathing, self-criticism, self-mutilation, suicidal ideation and self-destructive behaviors.

Conversely, women exhibited markedly higher frequencies in the Critical Demanding mode, indicating a pronounced proclivity towards pushing themselves to achieve exceedingly high standards, a tendency towards greater achievement orientation and emotional demand, a lack of self-perceived competence or capability, difficulty relaxing, a tendency to demand significant responsibilities from others, and a desire for complete control over themselves and the expression of their emotions or needs.

In light of the aforementioned observations, it becomes evident that the clinical population under study exhibits distinctive characteristics that align with the two poles of human organization proposed by Roediger et al. (2018).

In the assertiveness pole, attention is directed outwards, psychological reactions are characterized by the activation of the alarm system, social tendencies are towards autonomy and competition, self-centered and dominant, and metabolic tendencies are exhaustiveness. Motor tendencies are towards expansive activation,

reactive tendencies are fight or flight, and the active pole in child mode when there is a threat is the angry child. Internal criticism is directed more towards others, and action is external.

In the attachment pole, the focus of attention is directed towards oneself. The psychological reaction is calm and recreational. The social tendency is connection and empathy, prosocial and focused on achieving harmony. The metabolic tendency is regeneration. The motor tendency is towards the receptive reaction. The reactive tendency is submission. The active pole in child mode when there is a threat is the vulnerable child. The direction of the internal critics is more towards oneself. The direction of action is internal.

In light of the aforementioned considerations, it is intriguing to note that a discrepancy in emotional responses, beliefs, and coping mechanisms between men and women is observed in the low-resource clinical population within our specific context. Further research is required to ascertain whether pathological behaviors are associated with this rigidity of the personality based on gender. Additionally, greater clarity could be provided from the perspective of schema therapy on the resurgence of violence against women in recent times, which is enhanced by various social factors, including economic and cultural influences.

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