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ORIGINAL ARTICLE

Toxic masculinity and depression in men: A schema therapy perspective.

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Abstract

BACKGROUND: Toxic masculinity has increasingly been discussed as a significant psychosocial factor affecting men's mental health, particularly in relation to depression, self-stigma, and low rates of help-seeking. In clinical practice, however, the concept remains ambiguous and may be applied in a reductive or pathologizing manner. This article aims to provide a clinically sensitive understanding of toxic masculinity within the framework of schema therapy.

AIM: The aim of this article is to explore the relationship between toxic masculinity, early maladaptive schemas, and depressive symptomatology in men, and to demonstrate how schema therapy can facilitate long-term change without pathologizing male identity.

METHOD: This paper is a narrative review complemented by systematized clinical experience of schema therapists. Four composite heuristic vignettes are presented. These vignettes do not represent individual patients but are composite cases reflecting common clinical patterns. Each vignette includes schema-therapeutic conceptualization, a discussion of transgenerational transmission of masculine norms, and examples of therapeutic interventions.

CLINICAL ILLUSTRATIONS: Toxic masculinity is clinically expressed through specific early maladaptive schemas (e.g., emotional deprivation, unrelenting standards, emotional inhibition) and protective schema modes (Detached Protector, Overcontroller, Punitive/Demanding Critic). Depression in men often manifests through masked, externalizing, or somatic forms. Schema therapeutic interventions—including limited reparenting, imagery rescripting, chairwork, therapeutic letters, and transgenerational re-scripting—enable gradual access to unmet emotional needs and the strengthening of the Healthy Adult mode.
CONCLUSION: Toxic masculinity is conceptualized as a learned and modifiable pattern embedded in early maladaptive schemas and schema modes rather than as a stable personality trait. Schema therapy provides an integrative clinical framework that links gendered social norms with early maladaptive schemas and schema modes, and offers clinically applicable strategies for promoting sustainable change without pathologizing male identity.

INTRODUCTION

Clinical relevance of toxic masculinity in contemporary psychotherapy

The concept of toxic masculinity has entered psychological and psychiatric discourse with growing prominence over the past two decades. In scientific literature, it refers to socially constructed masculine norms that promote dominance, emotional suppression, devaluation of women, homophobia, and aggression (Kupers 2005). These norms have been associated with impaired mental health, relational difficulties, and reduced help-seeking among men (Connell & Messerschmidt 2005; Kupers 2005; River & Flood 2021).

Although the term originated in gender studies, it has gradually gained clinical relevance. In psychotherapeutic settings, toxic masculinity does not describe masculinity per se but rather rigid internalized expectations emphasizing emotional restraint, extreme self-reliance, invulnerability, and dominance (Connell & Messerschmidt 2005).

Such norms influence how men interpret distress, express symptoms, and engage in treatment. Across therapeutic orientations, clinicians observe that many male patients present late, often in crisis, and with pronounced shame or ambivalence toward psychological help (Addis & Mahalik 2003; Seidler *et al.* 2016).

Schema therapy offers a framework for understanding how culturally shaped masculine norms become internalized as early maladaptive schemas and schema modes. By integrating developmental experiences with current patterns of emotion regulation and self-evaluation, this approach conceptualizes male depression not simply as a mood disorder but as a long-term conflict between core emotional needs and rigid identity norms (Mahalik *et al.* 2007; Oliffe *et al.* 2012).

Prevalence of depression in men and specific patterns of manifestation

In men, depressive states frequently present in externalizing or masked forms rather than through prototypical symptoms such as sadness or tearfulness (Kessler *et al.* 2003; Rice *et al.* 2013). Irritability, anger, impulsivity, risk-taking, increased alcohol consumption, and overinvestment in work are common manifestations (Courtenay 2000; Oliffe & Phillips 2008).

These presentations contribute to underrecognition and misclassification, often as behavioral problems or substance-related disorders. A striking indicator of hidden burden is the substantially higher suicide rate among men in most countries despite lower reported rates of depression (Till *et al.* 2017). Delayed help-seeking, greater use of lethal means, and externalized distress likely contribute to this discrepancy.

Low rates of professional help seeking among men

Men consistently use mental health services less frequently than women across cultures and healthcare systems (Kessler *et al.* 2003; Galdas *et al.* 2005). When treatment is sought, it often follows prolonged distress or external pressure (Connell & Messerschmidt 2005; Seidler *et al.* 2016).

Adherence to traditional masculine norms is a robust predictor of negative attitudes toward psychological help. Systematic reviews and meta-analytic findings demonstrate a consistent negative association between traditional masculinity ideology and help-seeking intentions (Mokhwelepa & Sumbane 2025). Such norms emphasize self-sufficiency, emotional control, and avoidance of perceived weakness.

Self-stigma plays a central mediating role. Men who strongly internalize masculine norms are more likely to interpret depressive symptoms as personal failure rather than as a health condition, which reduces openness to professional support (APA 2006; Latalova *et al.* 2014). Higher endorsement of restrictive emotionality and self-reliance correlates with increased self-stigma and lower help-seeking intentions (Vogel *et al.* 2011; Levant *et al.* 2013).

Clinically, reluctance to engage in therapy often reflects identity threat rather than lack of motivation. The experience of depression directly conflicts with internalized ideals of autonomy and invulnerability, intensifying shame and avoidance.

Toxic masculinity as a transdiagnostic risk factor

Accumulating evidence suggests that rigid masculine norms function as transdiagnostic vulnerability factors rather than being associated with a single disorder (Seidler *et al.* 2016; Milner *et al.* 2019). They shape patterns of affect regulation, interpersonal behavior, and responses to stress across diagnostic categories.

These norms can be conceptualized as rigid cognitive and behavioral strategies aimed at minimizing shame and helplessness. While initially protective, long-term

reliance on suppression, control, and emotional detachment contributes to chronic dysregulation and relational strain.

Therapeutic approaches that target deeper personality structures, including schema therapy, are particularly suited to addressing these dynamics. By linking sociocultural norms with early developmental experiences and current schema modes, schema therapy translates abstract gender constructs into clinically actionable targets.

Aims and structure of the article

This narrative review integrates empirical literature with clinical schema therapy practice to clarify mechanisms linking toxic masculinity and male depression. It synthesizes research on masculinity, help-seeking, and schema processes and illustrates these mechanisms through composite clinical vignettes.

The first sections outline the conceptual background of toxic masculinity and its association with depressive symptomatology and help-seeking. Subsequent sections examine how internalized masculine norms are encoded within early maladaptive schemas and schema modes and how these patterns can be addressed through schema therapy interventions.

Despite extensive research on masculinity and men's mental health, clinically operational models linking sociocultural norms to intrapsychic mechanisms remain limited. Conceptualizing toxic masculinity within the schema therapy framework provides a structured approach for integrating identity, shame, transgenerational influences, and therapeutic change.

METHOD

Study design

This article adopts a narrative review design supplemented by structured clinical reflection and composite clinical vignettes. The topic of toxic masculinity lies at the intersection of clinical psychology, psychiatry, psychotherapy, and gender studies. Its conceptual complexity and transdiagnostic character make it unsuitable for reduction to a narrowly defined systematic review.

Narrative synthesis is appropriate when the aim is theoretical integration and clinical applicability rather than quantitative aggregation of outcomes (Green *et al.* 2006). The present framework integrates sociocultural constructs with schema therapy theory and practice to generate clinically testable propositions.

Selection and processing of the scientific literature

A targeted narrative literature search was conducted during the preparation of this article. The review focused on several interconnected thematic areas. These included toxic masculinity and hegemonic masculinity, masculinity and depression in men, help seeking behavior and self-stigma in men, gender related differences in the manifestation of psychological distress, and schema therapy with a focus on early maladaptive schemas and schema modes. The literature search was conducted primarily in the PubMed, PsycINFO, and Web of Science databases, covering publications from 2000 to 2025, with seminal works from earlier decades included selectively. Articles were included when they addressed at least one of the five thematic areas in the context of empirically investigated populations or provided foundational theoretical frameworks. Popular media sources, grey literature, and non-peer-reviewed commentaries were excluded. Formal saturation was not applied; thematic coverage was the criterion for closure. Only verifiable academic sources were retained. Popular or media interpretations of toxic masculinity were excluded to preserve conceptual precision and avoid moralizing framings.

Role of Clinical Experience

The theoretical synthesis is informed by long-term clinical practice in individual, group, and couple schema therapy with men presenting depressive, anxiety, relational, and substance-related difficulties. Clinical material was systematically reflected and abstracted to identify recurring intrapsychic patterns rather than isolated cases.

Clinical experience is not treated as anecdotal illustration but as structured phenomenological observation that allows translation of sociocultural constructs into therapeutic mechanisms.

Clinical Vignettes

The four vignettes represent composite clinical constructions derived from recurrent therapeutic patterns. They do not correspond to identifiable individuals or specific treatment courses. Their purpose is heuristic: to illustrate how internalized masculine norms become encoded in schemas and modes and how these dynamics can be modified through schema therapy interventions.

Ethical considerations

The manuscript contains no primary data and no identifiable patient information. All clinical material is synthesized and anonymized. Formal ethics committee approval was therefore not required.

Language throughout the manuscript aims to remain descriptive rather than pathologizing, particularly in relation to masculinity, identity, and vulnerability.

Methodological Limitations

The narrative design entails inherent limitations, including selective interpretation of literature and reliance on clinical synthesis. The framework presented should therefore be understood as a clinically grounded conceptual model rather than an empirically validated causal account.

Future research should subject the proposed mechanisms to systematic testing.

DEFINITION OF TOXIC MASCULINITY

Historical development

The term toxic masculinity emerged outside clinical psychology, initially within cultural debates on male identity (Connell & Messerschmidt 2005). Early references appeared in the mythopoetic men's movement, where "toxicity" denoted rigid, emotionally alienated, or violent expressions of masculinity (Kimmel 1996; Connell 2005; Herron *et al.* 2020).

Subsequently, gender theory reframed masculinity as a socially constructed and plural phenomenon shaped by power relations rather than biological essence (Connell 2005; Connell & Messerschmidt 2005). Within this framework, toxic masculinity refers to specific configurations of hegemonic masculinity associated with demonstrable psychological and social harm (Kupers 2005).

In clinical contexts, the term functions descriptively rather than diagnostically. It denotes internalized masculine norms linked to emotional suppression, exaggerated self-reliance, dominance, and shame surrounding vulnerability.

Distinguishing Masculinity, Hegemonic Masculinity, and Toxic Masculinity

Clear conceptual differentiation is essential. Masculinity refers broadly to culturally mediated meanings, roles, and practices associated with being male. It is historically variable and context-dependent (Connell 2005; Herron *et al.* 2020; Neilson *et al.* 2025).

Hegemonic masculinity denotes the culturally dominant and socially privileged form of masculinity that structures hierarchies among men and between genders (Connell & Messerschmidt 2005; Nordin *et al.* 2024). It represents an idealized standard rather than an empirical average. Toxic masculinity describes those rigid elements of masculine ideology associated with maladaptive psychological outcomes. Kupers conceptualized it as a constellation of socially regressive traits including dominance, devaluation of women, homophobia, and violence (Kupers 2005; Åhlander *et al.* 2023).

For clinical purposes, the focus is narrower: emotional inhibition, extreme self-control, rejection of dependence, and shame-based identity regulation (Vogel *et al.* 2011; Levant *et al.* 2013). These norms are relevant insofar as they shape vulnerability to depression and impede help-seeking (Addis & Mahalik 2003; Seidler *et al.* 2016; Call & Shafer 2015).

Conceptual Ambiguity and Risk of Stigmatization

The term carries semantic risk. In public discourse, it is often moralized and used as shorthand for "bad masculinity," which can reinforce defensiveness and shame. In psychotherapy, moralizing use of the concept may activate critical and protective modes, particularly in men who already experience high levels of self-stigma. Clinical utility therefore depends on precise, descriptive use that separates rigid norms from personal identity.

Toxic masculinity should not be equated with masculinity as such. It refers to inflexible identity prescriptions that constrain emotional and relational functioning.

Toxic Masculinity as Internalized Normative Regulation

From a psychological perspective, toxic masculinity is best conceptualized as internalized normative regulation acquired through socialization. These norms develop within family systems, peer groups, schools, and broader cultural narratives (Courtenay 2000; Mahalik *et al.* 2007).

They operate as implicit rules governing self-evaluation and emotion regulation: do not show weakness; remain self-sufficient; maintain control; avoid dependence.

Such rules may initially serve adaptive functions in demanding environments. Over time, rigid adherence restricts emotional flexibility, increases shame sensitivity, and limits access to corrective relational experiences.

Within schema therapy, these norms are encoded as early maladaptive schemas and protective modes rather than as fixed personality traits. They represent learned regulatory strategies shaped by developmental and sociocultural contingencies.

SOCIAL AND DEVELOPMENTAL CONTEXTS OF TOXIC MASCULINITY

Gender Socialization and the "Boys Don't Cry" Norm

Understanding toxic masculinity requires attention to early gender socialization. From childhood, boys receive explicit and implicit signals about which emotions are acceptable and which are not. One of the most consistently described norms is encapsulated in the phrase "boys don't cry." (Vogel *et al.* 2011).

This norm restricts more than the expression of sadness. It narrows the range of legitimate emotional states. Fear, shame, dependency, and the need for comfort are often discouraged, whereas anger, competitiveness, and emotional control are tolerated or rewarded (Kimmel 1996; Courtenay 2000; Horsfield *et al.* 2020).

Over time, such patterns limit opportunities to develop nuanced emotional awareness and regulation. Emotional expression becomes selectively inhibited rather than integrated. The result is not absence of emotion but constrained access to it.

Importantly, these norms are not communicated through isolated statements. They are reinforced repeatedly across contexts and gradually internalized as identity-defining rules.

Emotional Repression, Alexithymia, and Fear of Intimacy

Chronic reinforcement of emotional restraint may lead to restricted emotional awareness. Levant described this phenomenon as normative male alexithymia—culturally shaped difficulty in identifying and verbalizing emotions (Levant *et al.* 2013). This construct emphasizes social learning rather than individual deficit.

Empirical findings show that stronger endorsement of traditional masculine norms correlates with higher alexithymia, greater fear of intimacy, and more negative attitudes toward psychological help-seeking (Kupers 2005; Vogel *et al.* 2011; Sullivan *et al.* 2015).

Emotional inhibition in this context functions defensively. It protects against perceived identity threat. However, it also compromises relational depth and stress regulation.

Fear of intimacy does not imply lack of relational need. It reflects apprehension about emotional exposure and loss of control. Clinically, this may manifest as avoidance of affectively charged topics, preference for instrumental goals, or discomfort with therapeutic closeness.

Family, School, Peers, and Cultural Reinforcement

Gender socialization emerges within interconnected systems. Families play a primary role. Research indicates that boys' expressions of sadness and fear are more frequently discouraged than those of girls, while anger is more often tolerated (Chaplin & Aldao 2013).

Schools and peer groups reinforce masculine norms through social comparison, ridicule of deviation, and reward of dominance or performance. Bullying and exclusion often function as informal mechanisms regulating gender conformity (Kimmel 2008).

Broader cultural narratives further consolidate these patterns. Media portrayals, workplace expectations, and health behaviors communicate what is considered appropriate masculine conduct. In some working-class contexts, neglect of health, endurance of discomfort, and avoidance of preventive care are framed as markers of strength rather than risk (Dolan 2014).

These narratives rarely present themselves as ideological constructs. They are embedded in everyday practices and become normalized standards of adulthood (Kimmel 1996; Mahalik *et al.* 2007; Neilson *et al.* 2025).

Transgenerational Transmission of Masculine Norms

Masculine norms are often transmitted across generations through modeling, silence, and implicit expectations rather than explicit instruction (Kimmel 1996; Courtenay 2000; Herron *et al.* 2020).

Men raised in environments emphasizing endurance and emotional restraint frequently reproduce these patterns in parenting and partnerships. This transmission is typically unintentional, reflecting continuity of survival strategies rather than conscious ideology.

This process is not deterministic. Social change, reflective parenting, and psychotherapy can interrupt rigid transmission patterns. From a schema therapy perspective, early relational experiences encode these norms into schemas and protective modes. Adult intervention then becomes possible through experiential and relational work.

TOXIC MASCULINITY AND DEPRESSION IN MEN

Specific Features of Male Depression

Depression in men is frequently under-recognized rather than less prevalent. Epidemiological surveys report lower diagnosed rates compared with women, yet this difference is increasingly attributed to gendered symptom expression and diagnostic framing (Kessler *et al.* 2003; Kupers 2005; Oliffe *et al.* 2012).

Toxic masculinity-related norms influence not only whether distress is disclosed, but how it is experienced and enacted. Emotional vulnerability conflicts with internalized ideals of autonomy and control. As a result, depressive affect is often expressed indirectly.

Externalized and Atypical Presentations

In men, depressive pathology often presents through irritability, anger, impulsivity, risk-taking, substance use, and excessive work engagement (Courtenay 2000; Rice *et al.* 2013; Taylor *et al.* 2024).

These behaviors are frequently interpreted as personality traits, behavioral problems, or lifestyle choices rather than affective symptoms. Consequently, depression may remain clinically invisible until relational, occupational, or health-related consequences accumulate.

Qualitative studies indicate that in rural and working-class contexts, toughness and emotional stoicism further discourage explicit expression of sadness or hopelessness (Creighton *et al.* 2017). In such settings, endurance is valorized, and distress is reframed as personal weakness. Externalization does not reflect absence of depressive affect. It reflects a culturally mediated channel of its expression.

Masked Depression

Many men do not report classic symptoms such as sadness or tearfulness. Instead, depressive states may manifest as emotional numbness, cynicism, overinvestment in work, relational conflict, or somatic complaints (Lynch & Kilmartin 2013).

These patterns are consistent with masculine norms that stigmatize overt expressions of helplessness or worthlessness (Horsfield *et al.* 2020). Men redirect emotional pain into socially tolerated forms — anger, overperformance, detachment — leaving its underlying meaning unarticulated. Clinically, this masking complicates assessment and may delay intervention.

Self-Stigma and the Ideology of Self-Reliance

Self-stigma constitutes a central mechanism linking toxic masculinity to depression (Horsfield *et al.* 2020). Men who strongly endorse norms of autonomy and emotional control are more likely to interpret depressive symptoms as personal failure rather than legitimate illness (Vogel *et al.* 2011; Levant *et al.* 2013).

Masculine gender role stress has been shown to amplify help-seeking self-stigma, whereas self-compassion may partially buffer this effect (Booth *et al.* 2019).

The ideology of self-reliance intensifies this process. Depression directly contradicts internalized expectations of competence and invulnerability. The resulting identity dissonance promotes concealment, minimization, and prolonged untreated suffering (Addis & Mahalik 2003).

Empirical data suggest that self-stigma mediates the relationship between masculine norms and depressive severity. When vulnerability is equated with inadequacy, the disorder becomes not only symptomatic but existentially threatening (Seidler *et al.* 2016).

Recognition, Help-Seeking, and Treatment Adherence

Toxic masculine norms influence all stages of the clinical pathway: symptom recognition, help-seeking, and engagement in treatment.

Men socialized to suppress emotional awareness may struggle to label internal states accurately (Sullivan *et al.* 2015). Distress is often reframed as fatigue, stress, or performance difficulty rather than mood disturbance (Connell & Messerschmidt 2005).

Systematic reviews confirm a consistent negative association between traditional masculinity ideology and psychological help-seeking across cultures (Seidler *et al.* 2016; Galdas *et al.* 2005). A recent meta-analysis demonstrated this association at a cross-cultural level (Üzümçeker 2025)

Even after entering treatment, high endorsement of rigid masculine norms predicts greater dropout risk and avoidance of emotionally demanding interventions (Addis & Mahalik 2003; Arnocky & Vaillancourt 2014). These patterns are better understood as defensive adaptations than as lack of motivation (Connell & Messerschmidt 2005). Protective strategies that once safeguarded identity may become barriers to recovery.

TOXIC MASCULINITY IN THE CONTEXT OF EARLY MALADAPTIVE SCHEMAS

The schema therapy framework as a bridge between culture and intrapsychic experience

Schema therapy offers a unique conceptual framework for understanding how social and cultural norms, including norms of toxic masculinity, become internalized into stable intrapsychic structures that shape emotional experience, interpersonal behavior, and stress regulation. Within schema therapy, early maladaptive schemas are understood as deeply rooted patterns of memories, emotions, cognitions, and bodily reactions. They develop in childhood or adolescence as a result of unmet core emotional needs and are automatically activated in relevant situations in adulthood (Young *et al.* 2003; Arntz & Jacob 2013).

From the perspective of toxic masculinity, gender socialization plays a critical role in the systematic frustration of certain core emotional needs in boys. These include the need for safe emotional expression, acceptance of vulnerability, and unconditional validation. Such experiences are encoded into schemas that may later be misinterpreted as personality traits or as natural aspects of masculinity. In reality, they represent learned and potentially modifiable structures.

Schemas commonly associated with toxic masculinity

Emotional deprivation is among the most frequently observed schemas in men who grew up within rigid masculine norms. This schema develops when a child repeatedly experiences that emotional needs are unnoticed, minimized, or unmet. In boys, this process is often reinforced by gender socialization that implicitly or explicitly communicates that the need for comfort, understanding, or emotional closeness is inappropriate or weak (Courtenay 2000).

In adulthood, the emotional deprivation schema may manifest as feelings of inner emptiness, loneliness, and the belief that opening up is dangerous. Within the context of toxic masculinity, this schema is often masked by achievement striving, excessive control, or emotional distance. These compensatory strategies further complicate recognition of the schema in therapy.

Defectiveness and shame schemas are closely linked to an internalized sense of being fundamentally flawed, inadequate, or unworthy of acceptance. In men, these schemas may develop in situations where emotional sensitivity, dependence on others, or expressions of vulnerability were repeatedly criticized or ridiculed (Levant *et al.* 2013).

Toxic masculine norms amplify shame by framing emotional difficulties not only as personal problems but as violations of masculine identity. Recent evidence suggests that self-compassion may moderate this association, as higher self-compassion weakens the negative impact of masculinity ideologies on help-seeking intentions, even after experiences of interpersonal trauma (Komlenac *et al.* 2023). The result is often a profound inner conflict between the need for closeness and fear of exposing perceived weakness. Clinically, this schema may present as perfectionism, withdrawal from intimate relationships, or aggressive defenses against vulnerability.

The *schema of unrelenting standards* or perfectionism frequently develops in environments where personal worth is conditional upon performance, self-control, and competitiveness. When combined

with toxic masculinity, this schema reinforces rigid beliefs that failure is unacceptable and that rest, uncertainty, or help seeking signal weakness (Connell & Messerschmidt 2005; Young *et al.* 2003). In the short term, this schema may lead to high levels of productivity and social success. Over time, it increases vulnerability to burnout, depression, and psychosomatic symptoms. In therapy, it is often difficult to access because it is ego syntonic and socially rewarded.

Emotional inhibition represents a direct intrapsychic counterpart of the norm that men should not express vulnerability. This schema develops in environments where emotional expression was consistently punished, dismissed, or ignored. The individual learns that expressing emotions threatens relationships, social status, or personal safety and therefore suppresses them.

In adulthood, emotional inhibition manifests as restricted emotional experience, alexithymia, and difficulties in intimate relationships. Paradoxically, it may also lead to sudden emotional outbursts that reflect the accumulation of unexpressed affect over time.

Conceptualizing toxic masculinity through schemas and modes allows therapists to translate abstract gender norms into concrete clinical targets, thereby increasing both treatment precision and therapeutic alliance.

Recent empirical research has examined the relationships between early maladaptive schemas and male depression. Chodkiewicz *et al.* (2022) studied men aged 18 to 50, looking at both classic symptoms of depression, sadness, anxiety, and hopelessness, and atypical features more commonly seen in men: high stress levels, aggressiveness, difficulties with emotional regulation, alcohol use, and risky behaviors.

These atypical manifestations reflect schema-driven coping strategies rather than typical depressive presentations. Elevated stress shows up as physiological tension and irritable reactivity rather than acknowledged overwhelm. Aggressiveness masks underlying sadness and helplessness through verbal outbursts or hostile behaviors. Difficulties with emotional control involve paradoxical suppression of vulnerable emotions while experiencing dysregulation that gets expressed through anger. Alcohol abuse works as maladaptive self-medication, while risky behavior serves several functions: sensation-seeking to counter emotional numbness, validation of masculine identity, and unconscious self-destructive impulses.

The findings revealed strong positive correlations between male depression and all five schema domains, with the highest correlations for "Disconnection and rejection," "Other-directedness," and "Overvigilance and inhibition." Crucially, regression analyses in one study (Chodkiewicz *et al.* 2022) demonstrated that 'Disconnection and rejection' and 'Impaired autonomy and performance' together accounted for over 60% of variance in atypical male depression scores — a finding that warrants replication before it can be treated as established. By contrast, "Impaired limits" predicted only classic depressive symptoms, not atypical manifestations (Chodkiewicz *et al.* 2022). The centrality of "Impaired autonomy and performance" to atypical symptoms is theoretically coherent. Men with schemas of Dependence/Incompetence and Failure to Achieve had childhood environments emphasizing overprotection and undermined competence. When confronted with cultural imperatives demanding autonomy and achievement, these men face profound identity threat. The resulting conflict does not manifest as sadness but as compensatory hypermasculine behaviors—aggressiveness to prove strength, risk-taking to demonstrate fearlessness, and substance use to manage feelings of inadequacy (Young *et al.* 2003).

The relationship between schemas and gender norms

Within schema therapy, toxic masculine norms can be understood as external sources of repeated experiences that contribute to the development and maintenance of specific schemas. These perspectives operate at different explanatory levels and are conceptually complementary (Young *et al.* 2003). Social norms provide the contextual framework, while schemas describe the intrapsychic imprint of these norms.

This conceptualization allows therapists to address toxic masculinity without moralizing or reducing the problem to maladaptive attitudes. Schemas are understood as adaptive responses to the environment that lose their protective function in adulthood.

Schemas as internal carriers of toxic ideals

Early maladaptive schemas can be viewed as internal carriers of toxic ideals that originally existed within the family, school, or broader culture. These ideals are no longer maintained through external pressure. They operate autonomously through an internal critic, excessive demands, and rigid rules.

This perspective is essential for therapeutic work because it enables externalization of the problem and reduces shame and self-criticism. It also creates space for the development of a healthier and more flexible masculine identity. In the following chapters, this framework will be further elaborated through the schema mode model and specific therapeutic interventions.

To summarize the proposed clinical mechanism, Figure 1 presents an integrative pathway linking internalized toxic masculinity-related norms to early maladaptive schemas, schema modes, common depressive presentations in men – summarized through schema coping styles (Young *et al.* 2003; Arntz *et al.* 2021) and corresponding schema therapy intervention targets. The model is intended as a clinically informed conceptual map rather than a causal claim. In this model, toxic masculinity-related norms are not treated as sole causal factors. Rather, they are conceptualized as sociocultural learning processes that can amplify, channel, or maintain schema-related vulnerability and protective regulation strategies. Importantly, schema

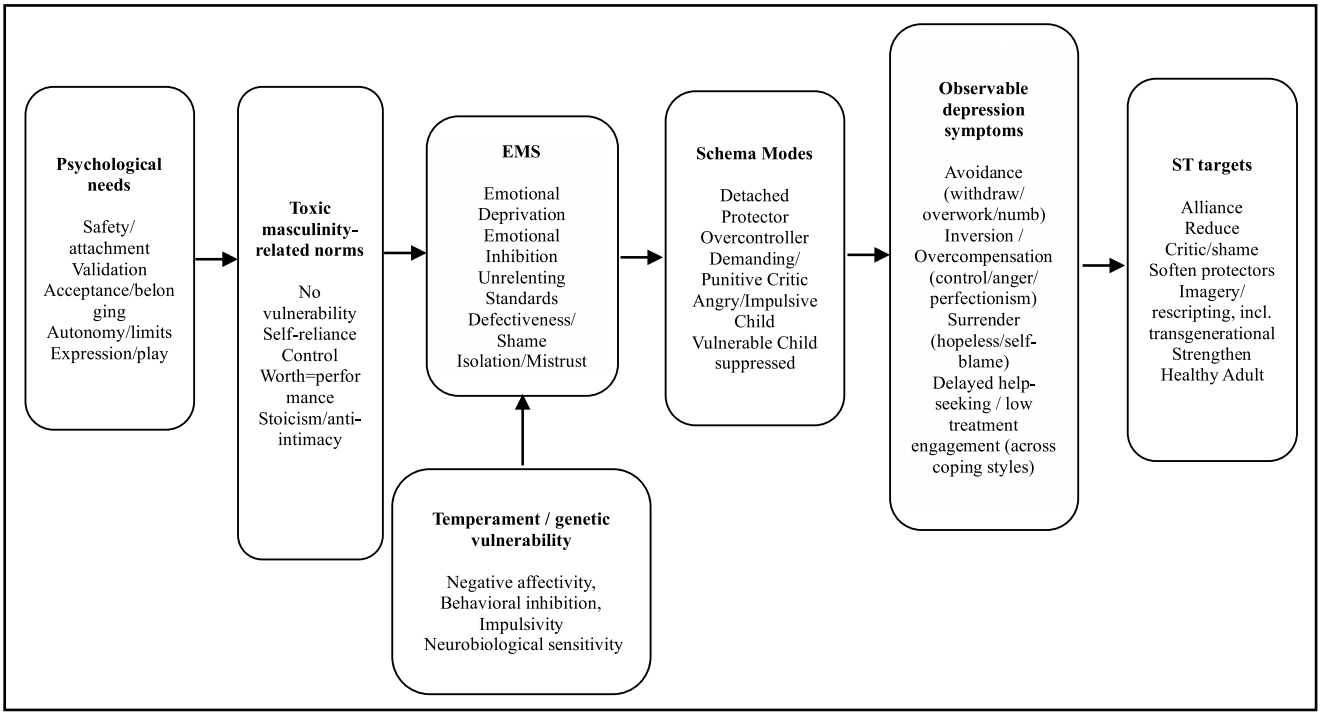

Fig. 1. An integrative schema therapy model linking toxic masculinity-related norms to depression in men

Legend: The model presents a clinically informed conceptual pathway, not an empirically validated causal chain. Arrows indicate theorized directional influence; bidirectional effects are acknowledged but not depicted for visual clarity. Toxic masculinity-related norms are positioned as sociocultural amplifiers of schema vulnerability rather than as sole causal agents. Temperament and genetic vulnerability (bottom) function as moderating inputs that interact with early relational experiences to shape schema formation. EMS = Early Maladaptive Schemas. Mode terminology follows Arntz *et al.*. (2021). ST Targets = Schema Therapy intervention targets.

development is multifactorial. Temperamental and genetic influences shape emotional sensitivity, stress reactivity, and self-regulatory capacity, which interact with early relational experiences.

THE SCHEMA MODE MODEL AND TOXIC MASCULINITY

The mode model as a dynamic map of male experience

Modes represent temporary states of mind that include specific emotions, cognitions, bodily reactions, and behavioral strategies. These states fluctuate in response to internal or external triggers (Young *et al.* 2003; Arntz *et al.* 2021).

In the context of toxic masculinity, the mode model is particularly valuable. It helps explain how internalized masculine norms become active in everyday functioning. It shows how these norms are triggered in situations that threaten identity and how they regulate shame, helplessness, and fear in the short term. The model also provides therapists with a non-pathologizing language that supports externalization of the problem. This approach is especially important for men with high levels of self-criticism and resistance.

Typical schema modes in men with toxic masculine norms

The *Detached Protector* is one of the most frequently activated modes in men raised within rigid masculine norms. Its primary function is to minimize emotional pain through withdrawal from contact. This withdrawal occurs both internally and interpersonally. Emotional experience becomes blunted, bodily awareness is reduced, and relationships are limited to functional or instrumental interactions (Young *et al.* 2003).

In clinical practice, this mode often presents as emotional flatness, intellectualization, irony, or excessive focus on performance. Within the therapeutic relationship, it may be misinterpreted as lack of motivation or emotional immaturity. In reality, it represents a highly adaptive defense against shame and vulnerability. In the context of toxic masculinity, the Detached Protector is often reinforced by social approval of emotional restraint and autonomy.

The *Overcontroller* represents an active protective strategy aimed at preventing chaos, failure, and loss of control. This mode is frequently grounded in schemas of unrelenting standards and defectiveness. It is closely linked to ideals of masculine self-control and dominance (Young *et al.* 2003).

In men with toxic masculine norms, the Overcontroller manifests as rigid planning, perfectionism, intolerance of uncertainty, and limited capacity to delegate or accept help. Emotions are experienced as disruptive elements that must be suppressed or managed. In the short term, this mode enhances feelings of competence and safety. Over time, it contributes

to exhaustion, relational conflict, and impaired adaptive stress regulation.

The *Demanding Critic* mode represents the internalized voice of social and familial norms that evaluate, punish, and shame. In the context of toxic masculinity, this mode often conveys messages such as the need to be strong, the prohibition of failure, and the belief that emotions signify weakness.

The *Critic mode* is a central carrier of shame and self-stigmatization (Horsfield *et al.* 2020). It becomes particularly active when a man experiences helplessness, sadness, or the need for support. These experiences are immediately delegitimized. In therapy, this mode is often highly rigid. Its internalization tends to be deep because it has been reinforced over many years by cultural ideals of masculinity.

Despite the dominance of protective modes, the Vulnerable Child mode remains present in most men. This mode carries the original emotional pain related to unmet needs, shame, and loneliness. In the context of toxic masculinity, however, it is often dissociated or strongly suppressed. Activation of this mode is associated with threats to identity and loss of control (Young *et al.* 2003).

Clinically, the *Vulnerable Child* may appear indirectly. It may be expressed through somatic symptoms, sudden affective collapses, impulsive reactions, or addictive behaviors. Access to this mode is essential for therapeutic change. It requires a safe therapeutic relationship and gradual weakening of protective modes.

The function of modes in regulating shame and helplessness

From a schema therapy perspective, protective modes can be understood as strategies for regulating shame and helplessness. These strategies develop in environments where such emotions were neither safely accepted nor processed. Toxic masculine norms act as secondary reinforcing factors. They legitimize the use of protective modes and further restrict access to core emotional needs.

Withdrawal, control, and self-criticism allow men to function in the short term and maintain a socially acceptable identity. At the same time, these strategies prevent corrective emotional experiences that are necessary for long term change.

The cost of long-term reliance on protective modes

Although protective modes are initially adaptive, their rigid and prolonged use carries significant psychological and relational costs. These costs include chronic emotional emptiness and alienation, reduced capacity for intimacy, increased vulnerability to depression, anxiety, and addictions, and a rigid self-concept with limited flexibility under stress.

The therapeutic goal is to reduce rigidity of protective modes while strengthening the Healthy Adult mode — understanding its function and reducing dominance rather than eliminating it (Young *et al.* 2003; Arntz *et al.* 2021).

SCHEMA THERAPY INTERVENTIONS FOR MEN WITH TOXIC MASCULINITY

Working with men who strongly internalize toxic masculine norms requires careful pacing and identity-sensitive framing. The task is not limited to technical application of schema therapy methods. It requires sensitive balancing of safety, respect for identity, and gradual expansion of emotional capacity. Therapeutic interventions must not be experienced as a threat to masculinity. They should be framed as an extension and integration of masculine identity. The therapeutic work with male depression should simultaneously address dominant maladaptive schemas and beliefs about stereotypical male roles (Chodkiewicz *et al.* 2022). This dual focus is essential because atypical manifestations represent the intersection of intrapsychic vulnerability and gendered social norms. Schema therapy's framework for validating unmet needs and challenging punitive self-evaluation addresses both dimensions without pathologizing male identity (Chodkiewicz *et al.* 2022).

Limited reparenting and the creation of safety

Limited reparenting is the foundational relational stance of the schema therapist — a bounded corrective relationship in which the therapist offers, within professional limits, the emotional responsiveness the patient did not receive in early development. Many of these men grew up in environments where emotional needs were not acknowledged or were actively devalued. The therapeutic relationship often becomes the first context in which vulnerability is accepted without conditions related to performance or control (Young *et al.* 2003; Arntz *et al.* 2021).

In practice, this means that the therapist actively models a stable, respectful, and emotionally safe relationship in which emotions are legitimate. With male patients, it is often necessary to proceed gradually. Initial validation may focus on exhaustion or frustration rather than directly addressing sadness.

For example, a man with depression describes chronic work overload and irritability. The therapist responds by acknowledging the strain and normalizing the need for rest. The emphasis is placed on sustainability rather than weakness. This approach validates emotional experience without directly challenging masculine identity.

Normalizing emotions without threatening identity

One of the central therapeutic tasks is to normalize emotional experience in a way that does not activate shame or the Demanding Critic mode. Direct invitations to open emotional expression may increase resistance. It is often more effective to use functional language that links emotions to adaptation, performance, and long-term stability (Addis & Mahalik 2003).

The therapist may frame emotions as sources of information rather than as signs of weakness. This framing is usually more acceptable to men and reduces defensive reactions. Emotional awareness is presented as a resource rather than a liability.

Working with shame and self-stigmatization

Shame is a central affect in men with toxic masculinity. It is often hidden behind anger, irony, or emotional distance. Schema therapy enables work with shame through externalization of the Demanding Critic and gradual development of a more compassionate internal dialogue (Young *et al.* 2003; Gilbert & Procter 2006; Maner *et al.* 2023).

Self-stigmatization is frequently reinforced by beliefs emphasizing self-sufficiency and comparison with others. The therapist helps separate personal worth from current functioning. Needing help is reframed as a consequence of prolonged strain rather than personal failure.

Imagery rescripting and early gender socialization

Imagery rescripting is a particularly effective method for addressing early experiences of gender socialization. Many men report memories in which they were mocked or punished for crying, fear, or seeking closeness (Arntz 2012).

During rescripting, the therapist enters the memory and provides protection, validation, and corrective emotional experience to the Vulnerable Child. Sensitivity to pacing and emotional tolerance is essential, as imagery work can be highly intense for men who have long suppressed vulnerability.

The therapeutic message emphasizes that emotional pain is meaningful and legitimate. Emotional expression is reframed as a signal of unmet needs rather than as weakness.

Chairwork and dialogue between modes

Chairwork enables concrete and structured dialogue between schema modes. In men, this technique is often surprisingly effective because it externalizes internal conflicts and provides clarity (Young *et al.* 2003).

In therapy, the Critical mode is identified as a demanding and shaming voice. The protective function of the Detached Protector is acknowledged. Gradual access to the Vulnerable Child is then facilitated. The therapist supports the Healthy Adult in responding to inner criticism with care rather than submission or avoidance.

This process helps men experience internal authority without relying on harsh self-control.

Therapeutic letters as tools for externalization and integration

Therapeutic letters represent a valuable schema therapy intervention that integrates cognitive reflection with emotional processing (Prasko *et al.* 2024). They also provide structure, which many men experience as safer than immediate emotional exposure (Young *et al.* 2003; Kellogg & Young 2006; Arntz 2012).

In men with toxic masculinity, letters allow indirect expression of vulnerability with temporal distance and a sense of control. Writing may involve addressing the Critical mode, offering care to the Vulnerable Child, or speaking to significant figures from the past without intention to send the letter (Prasko *et al.* 2024).

These letters function as transitional objects. They facilitate contact with shame and emotional pain without overwhelming the patient. At the same time, they support development of the Healthy Adult, who can reflect on past experiences with distance and compassion.

The Life River method and narrative integration of masculine identity

The Life River technique supports structured work with the life narrative (Prasko *et al.* 2024). It is particularly suitable for men who view their lives primarily through performance, tasks, and crises rather than emotional meaning. In the context of toxic masculinity, this method helps externalize rigid narratives about what a man should be and supports development of a broader and more flexible self-concept.

The patient is guided to represent life as a river with calm sections, rapids, obstacles, and periods of drought. The therapist assists in identifying emotionally painful moments, turning points linked to gender expectations, and survival strategies that were once adaptive but are no longer helpful.

This method normalizes protective strategies such as control, performance orientation, and emotional distance as developmental responses rather than failures. It also creates space for reassessment in adulthood.

Transgenerational rescripting and inherited masculine norms

Transgenerational rescripting extends imagery work by addressing the transmission of masculine norms across generations (Prasko *et al.* 2025). In many men, the Demanding Critic carries not only personal history but also the voices of fathers, grandfathers, and broader cultural contexts shaped by trauma, war, poverty, or social pressure (Young *et al.* 2003).

In therapy, the patient explores the origins of these norms, distinguishes what was adaptive in the past from what is harmful in the present, and symbolically returns burdens that do not belong to him.

This process often leads to significant reduction of shame and supports redefinition of masculinity as a conscious choice rather than a fixed destiny. It strengthens the Healthy Adult, who integrates respect for previous generations with protection of current emotional needs.

Strengthening the Healthy Adult and redefining masculine identity

The goal of schema therapy is not to eliminate masculinity. The aim is to integrate strength, responsibility, and vulnerability into a functional Healthy Adult mode. In men, this often involves redefining masculine identity to include relational needs, self-care, and the capacity to ask for help (Connell & Messerschmidt 2005; Young *et al.* 2003; Prasko *et al.* 2025).

The therapist actively supports development of new narratives in which emotional awareness is linked to stability rather than weakness. This redefinition is essential for long term change and relapse prevention.

Integration of techniques in the therapeutic process

Therapeutic letters, the Life River method, and transgenerational rescripting are not isolated techniques (Prasko *et al.* 2024). They function as complementary strategies that support safe access to the Vulnerable Child, reduce dominance of the Demanding Critic, increase flexibility of protective modes, and strengthen the Healthy Adult narrative. They also allow natural emotions associated with the Happy Child to reemerge.

When combined with chairwork and imagery rescripting, these methods create a deeply integrative therapeutic framework. This framework is particularly suitable for men whose difficulties are rooted in rigid and transgenerationally transmitted masculine norms.

CLINICAL ILLUSTRATIONS

CLINICAL VIGNETTE 1: "I HAVE TO ENDURE. OTHERWISE, I FAIL."

Patient characteristics

The patient is a 47-year-old man with university education who works in a managerial position in a medium sized company. He is married and has two adolescent children. He entered therapy on the recommendation of his general practitioner after several months of sick leave due to exhaustion, insomnia, and somatic complaints, including headaches and chronic muscle tension. He initially denied depressive symptoms and described his condition as "a collapse from overwork."

Family and transgenerational context

The patient grew up in a family in which the father was a dominant and emotionally distant man who worked in manual labor throughout his life. He repeatedly emphasized values such as toughness, endurance, and responsibility. The paternal grandfather was a war veteran who returned from military service with pronounced emotional numbing and alcohol dependence. These issues were not discussed within the family.

Emotions were implicitly framed as weakness within the family system. A typical family message was, "Men do not complain. They just handle it."

These patterns were not only internalized by the patient but also reproduced in his own parenting. He described his approach to raising his children as "strict but fair," with little space for emotional dialogue.

Schema therapy conceptualization

The clinical formulation highlighted the prominence of schemas, which included unrelenting standards and perfectionism, in which self-worth was contingent upon performance and control. Emotional inhibition was present, with emotional experience perceived as threatening and illegitimate. Emotional deprivation was evident in the belief that support and understanding were unavailable. A latent defectiveness and shame schema was also present, reflecting fear that failure would expose inner weakness.

Within the schema mode model, functioning was dominated by an Overcontroller mode in work and family life, a Detached Protector characterized by emotional distance, and a strong Demanding Critic carrying the internalized voice of the father. The Vulnerable Child mode had been dissociated for many years.

Trigger of depression and development of symptoms

The depressive episode was triggered by a combination of factors. These included organizational restructuring at work, increased responsibility, and health problems experienced by the patient's wife. The patient responded by further increasing work effort and control. This led to progressive exhaustion.

The clinical picture was characterized by irritability, sleep disturbance, and somatic tension, without overt sadness.

Course of therapy and selected interventions

Chairwork and dialogue between the Demanding Critic and the Vulnerable Child

After establishing a therapeutic alliance, chairwork was used to externalize the Demanding Critic.

The Demanding Critic, voiced by the patient, stated, "If you let go, everything will fall apart. You have no right to be weak."

The therapist responded, "Try moving to the other chair. Who is sitting there?"

After a long pause, the patient said, "There is a boy. He is about ten years old. He is afraid that if he fails, he will be useless."

This moment represented the first direct contact with the Vulnerable Child mode. The therapist then entered a limited reparenting role and validated the child's emotional experience. The therapist said, "That boy does not need someone to push him harder. He needs to know that he has value even when he is exhausted."

Imagery rescripting with a transgenerational focus

In a later phase, imagery rescripting was used to address an early memory in which the patient's father responded with ridicule when the patient cried after failing at school.

In the imagery, the therapist stepped between the father and the child and provided protection. The image of the grandfather was then introduced, creating a transgenerational rescripting process.

In the imagery, the patient said, "I see that this is how you learned to survive. But I do not want to survive like this anymore."

This intervention led to marked emotional release and a significant reduction in self-criticism.

Schema therapy-based analysis

Clinically, the depressive state reflected the exhaustion of long-standing coping configurations rooted in early maladaptive schemas. The Overcontroller and Detached Protector had been functional for decades but at the cost of chronic suppression of core emotional needs.

Naming and personifying the Demanding Critic reduced its absolute authority. Therapy permitted externalization of the Demanding Critic mode as a mover of intergenerationally transmitted expectations. It legitimized the emotional needs of the Vulnerable Child. It also bound the Healthy Adult mode, which began to redefine masculinity not as endurance at any cost but as the ability to recognize limits and engage in self-care. Gradually, a more balanced and reflective self-position began to consolidate.

Over the course of therapy, depressive symptoms gradually diminished. The patient began delegating work responsibilities, communicating more openly within his family, and reevaluating life priorities.

CLINICAL VIGNETTE 2: "IF I LET GO, EVERYTHING WILL FALL APART."

Patient characteristics

The patient is a 29-year-old man with vocational training as a mechanic. He currently works in shift work at a logistics warehouse. He lives with his partner and has no children. He entered therapy on the recommendation of an addiction specialist, whom he consulted due to excessive alcohol use and episodic use of stimulants. He reported feelings of emptiness, outbursts of anger, insomnia, and recurrent conflicts in his intimate relationship. He rejected the idea of depression, describing it as "something for weak people."

Family and transgenerational context

The patient grew up in a family with low socioeconomic status. His father was long term unemployed, struggled with problematic alcohol use, and was emotionally unavailable and occasionally physically aggressive. His mother worked two jobs and was chronically exhausted. During adolescence, the patient assumed the role of "the man of the family." He protected his younger siblings and attempted to maintain basic family functioning.

According to family narratives, the paternal grandfather was described as a "tough man" who survived severe work-related injuries and viewed alcohol as a normal part of male life. Emotional topics were systematically avoided in the family. Weakness was punished through ridicule or violence.

The implicit family message was clear: "Be tough, or you will be crushed."

Schema therapy conceptualization

The dominant schema configuration included defectiveness and shame, characterized by a deep sense that something was fundamentally wrong with him. Emotional deprivation was present in the belief that asking for help was pointless and that no one would truly respond. Insufficient self-control and self-discipline manifested as oscillation between rigid control and impulsive behavior. Emotional inhibition was also present, with emotions experienced as dangerous and associated with loss of control.

From a schema mode perspective, functioning was dominated by the Detached Protector, expressed through emotional numbing and cynicism, and the Impulsive Child, expressed through alcohol use and interpersonal conflict. A strong Demanding Critic carried the internalized voice of the father. The Vulnerable Child mode was active but largely unprotected.

Trigger of depression and development of symptoms

The development of depressive symptoms followed cumulative stressors, including loss of a previous job, escalating conflicts with his partner, and a growing sense of failure. The patient responded with increased alcohol consumption and aggressive outbursts.

Distress was expressed primarily through behavioral dysregulation rather than affective disclosure. Symptoms included irritability, impulsivity, risk taking behavior, and persistent feelings of emptiness and hopelessness. Open sadness was absent.

Course of therapy and selected interventions

Normalization of emotions and work with shame

In the early phase of therapy, it was essential to normalize emotional experience without activating shame. The therapist avoided diagnostic labels and used language focused on burden and survival.

The therapist said, "What you describe does not look like weakness. It looks like someone who has been carrying everything alone for a very long time."

This intervention allowed the patient to recognize that his survival strategies had once been adaptive but had become destructive in his current life.

Chairwork and dialogue between the Demanding Critic and the Healthy Adult

In a later phase, chairwork was introduced.

The Demanding Critic, voiced by the patient, stated, "Stop feeling sorry for yourself. No one is going to do it for you."

The therapist responded, "Try sitting in the Healthy Adult chair. How would you answer him today?"

The patient hesitated and then said, "Maybe that he does not have to manage everything alone anymore. That asking for help does not mean he is useless."

This moment represented the first explicit weakening of Demanding Critic mode.

Therapeutic letter to the father

The patient was invited to write a therapeutic letter to his father that was not intended to be sent.

In the letter, he wrote, "I never knew if I was good enough for you. So I tried to be tough. But inside, I was always a boy who was afraid."

The letter enabled contact with the Vulnerable Child without direct confrontation. In the following weeks, it was associated with reduced impulsivity and improved emotional regulation.

Schema therapy-based analysis

From a schema therapy perspective, the patient's depression can be understood as the consequence of chronic activation

of protective and impulsive modes that developed in an environment marked by threat and neglect. Alcohol functioned as a maladaptive regulator of affect and a temporary escape from shame and helplessness.

Therapy facilitated externalization of the Critical mode as a voice of transgenerational trauma. It supported gradual strengthening of the Healthy Adult. It also contributed to the development of an alternative narrative of masculinity that includes responsibility alongside the need for support.

Depressive symptoms gradually decreased in parallel with reduced alcohol use and improved relational functioning.

CLINICAL VIGNETTE 3: "I DO NOT FEEL ANYTHING ANYMORE, AND THAT SEEMS FINE."

Patient characteristics

The patient is a 61-year-old man with secondary education who has worked for many years as a technician in the energy sector. He is recently divorced after a thirty-year marriage and has two adult children. He entered therapy on the recommendation of his general practitioner due to long standing somatic complaints, including back pain, hypertension, gastrointestinal problems, and insomnia. Subjectively, he described a sense of emptiness, loss of meaning, and withdrawal from social contact. He denied depression and stated that he had "gotten used to feeling nothing."

Family and transgenerational context

The patient grew up in a post war family environment. His father worked as a railway employee and was a quiet, strict man who had experienced material deprivation during childhood. Emotions were not expressed in the family. Praise was rare and care was largely instrumental. The paternal grandfather worked in physically demanding jobs throughout his life and was described as "honest but hard." Traumatic experiences were not discussed.

A family motto frequently mentioned by the patient was, "Just do what you are supposed to do. Feelings are not talked about."

These norms were transferred into the patient's own marriage. He described himself as reliable and responsible but emotionally unavailable. The divorce was initiated by his wife after many years of feeling lonely within the relationship.

Schema therapy conceptualization

Several early maladaptive schemas were identified. Emotional deprivation was evident in the belief that emotional closeness was unavailable or unnecessary. Emotional inhibition was present as a long-term strategy of affect suppression. A latent defectiveness and shame schema reflected feelings of inadequacy related to being "unable to be different." Social isolation was also present, characterized by a sense of separateness and disconnection from others.

The schema mode profile was dominated by the Detached Protector, expressed through emotional numbing and somatization. A strong Demanding Critic conveyed messages such as "do not burden others" and "endure." The Vulnerable Child had been dissociated for many years. The Healthy Adult mode was weakly developed.

Trigger of depression and development of symptoms

The divorce and the departure of the children from the household disrupted the long-standing structure of the patient's life. Loss of the role of provider and organizer activated the emotional deprivation schema and led to collapse of detached regulation. Symptoms were predominantly somatic and anhedonic, with minimal subjective reporting of low mood.

Course of therapy and selected interventions

Limited reparenting and validation of emotional numbness

In the initial phase of therapy, it was essential not to pathologize emotional numbness.

The therapist said, "The fact that you do not feel anything right now may be the way your mind protected you for a long time."

This validation reduced defensive reactions and allowed gradual access to the Vulnerable Child without activating shame.

The Life River method and narrative integration

The Life River method was used to map life stages and personal meaning.

The patient said, "The river is straight. No bends. Just work and duties. And now there is emptiness."

The therapist responded, "That straight line may have helped you survive. But today there may be space for the river to widen."

This technique normalized protective strategies and opened the question of identity reconstruction in later life.

Imagery rescripting with a transgenerational focus

In imagery work, the patient revisited a memory in which he was ignored as a child when expressing fear. The therapist entered the scene and provided protection. The image of the father was then introduced.

In the imagery, the patient said, "I see that you did not know how to do it either. But I do not want to stay silent anymore."

This transgenerational rescripting led to the first conscious contact with sadness and was accompanied by a reduction in somatic symptoms.

Therapeutic letter to the former spouse

The patient wrote a therapeutic letter to his former wife that was not intended to be sent.

In the letter, he wrote, "I never knew how to tell you that I needed you. I thought you would understand because I endured."

The letter supported emotional integration and strengthening of the Healthy Adult mode.

Schema Therapy-Based Analysis

The episode emerged when entrenched schema-based defenses lost their stabilizing function. The patient's depression developed as a consequence of the long-term dominance of the Detached Protector mode. This mode was socially reinforced and functionally stable for many years. At the same time, it blocked access to core emotional needs. A major life transition, namely divorce, removed external structures that had supported detached functioning and exposed the unmet needs of the Vulnerable Child.

Therapy made it possible to legitimize emotional numbness as a protective strategy rather than a deficit. It gradually weakened the Critical mode that carried transgenerational norms

of endurance and emotional restraint. It also supported development of the Healthy Adult, who began to integrate responsibility with the need for closeness.
Over time, the patient renewed social contacts, started to name emotions more explicitly, and redefined masculine identity as the capacity to be emotionally present rather than merely to endure.

CLINICAL VIGNETTE 4: "I UNDERSTAND IT, BUT I DO NOT FEEL IT."

Patient characteristics
The patient is a 35-year-old man with a university degree who works as a researcher in a technical academic field. He lives with his partner and has no children. He sought therapy on his own initiative after noticing a long-term decline in motivation, inability to experience joy, and increasing cynicism. He reported sleep disturbances, inner tension, and a sense that "life is moving on, but I am not really part of it." He initially conceptualized depression as a cognitive rather than emotional problem.

Family and transgenerational context
The patient grew up in a family with a strong emphasis on education and performance. His father was a successful engineer who was emotionally reserved and highly perfectionistic. The paternal grandfather was a university professor known for intellectual brilliance as well as emotional distance and limited involvement in family relationships. Emotions were tolerated in the family only when they could be rationally justified.
The implicit family message was, "If you think well enough, emotions are not necessary."
The patient was primarily valued for achievements and his ability to keep things under control. Failure or uncertainty were subtly questioned or devalued.

Schema therapy conceptualization
Assessment revealed a constellation of schemas centered around unrelenting standards and perfectionism, in which self-worth was contingent on excellence. Emotional inhibition was present, with emotions experienced as disruptive to cognitive functioning. Emotional deprivation was evident in the belief that emotional closeness was unavailable. A latent defectiveness and shame schema was activated when control was lost.
The schema mode profile was dominated by a Detached Protector expressed through intellectualization and emotional distance. An active Overcontroller was also present. The Demanding Critic conveyed messages such as "you must be better." The Vulnerable Child had been suppressed for a long time and remained largely inaccessible.

Trigger of depression and development of symptoms
The depressive episode was triggered by failure in a competitive grant application combined with conflict in the intimate relationship. The patient was confronted with criticism regarding emotional absence. These events activated the defectiveness schema and disrupted long standing control strategies.
The depressive state presented chiefly as an existential and cognitive constriction rather than overt affective collapse.

Course of therapy and selected interventions
Normalization of protective strategies and work with the Detached Protector
In the initial phase of therapy, it was essential not to attack intellectualization. It was framed as a protective strategy.
The therapist said, "It seems that thinking helped you survive for a long time. Maybe it just stopped being enough."
This formulation reduced defensiveness and facilitated emotional engagement.

Chairwork and dialogue between the Demanding Critic and the Vulnerable Child
Chairwork was used to externalize the Demanding Critic.
The Demanding Critic said, "If you are not exceptional, you are worthless."
The therapist responded, "Try moving to the other chair. Who is hearing this?"
The patient said quietly, "A boy who is afraid that if he lets go, he will disappear."
This moment enabled the first direct contact with the Vulnerable Child.

Imagery rescripting with a transgenerational focus
The patient worked with an image of a childhood situation in which he received praise for academic success without emotional response. The therapist entered the scene and provided validation. Images of the father and grandfather were then introduced.
In the imagery, the patient said, "You taught me how to think. Now I am learning how to feel."
This rescripting led to significant emotional release and reduced perfectionistic pressure.

Therapeutic letter from the Healthy Adult to the child self
The patient wrote a therapeutic letter to himself as a child.
In the letter, he wrote, "You do not have to be the best in order to have the right to exist."
The letter built the Healthy Adult mode and supported gradual integration of emotions into identity.

Schema therapy-based analysis
From a schema therapy view, the patient's depression developed as a consequence of rigid dominance of cognitively oriented protective modes that blocked access to emotional needs over time. Toxic masculinity manifested here in a subtle form. It did not appear through aggression or overt performance pressure. It appeared through privileging rationality and rejecting vulnerability.
The therapeutic process gradually reduced the dominance of inherited performance ideals and created space for emotional experience. Rather than abandoning competence, the patient integrated affective awareness into his identity. This shift was associated with renewed vitality and more authentic relational engagement.

Comparison of clinical vignettes

The following comparative overview synthesizes the four clinical vignettes and highlights both shared and distinct patterns in the manifestation of toxic

Tab. 1. Comparative overview of clinical vignettes

Domain	Vignette 1	Vignette 2	Vignette 3	Vignette 4
Age and context	47 years, manager	29 years, manual labor	61 years, technician	35 years, academic
Social class	Middle to upper	Lower	Middle	Middle to upper
Transgenerational pattern	War trauma, performance, silence	Alcohol use, violence, survival	Post war toughness, duty	Intellectualization, excellence
Core family message	"Endure and do not burden others"	"Be tough or you will be destroyed"	"Do your duty, do not talk"	"Reason over emotions"
Dominant schemas	Unrelenting standards, emotional deprivation	Defectiveness, emotional deprivation	Emotional deprivation, emotional inhibition	Unrelenting standards, emotional inhibition
Type of depression	Masked, burnout related	Externalized, addiction related	Somatized, anhedonic	Internalized, existential
Dominant modes	Overcontroller, Demanding Critic	Detached Protector, Impulsive Child	Detached Protector	Detached Protector, Overcontroller
State of the Vulnerable Child	Dissociated	Active but unprotected	Strongly dissociated	Suppressed
Key interventions	Chairwork, imagery rescripting	Normalization, letters, chairwork	Life River, rescripting	Chairwork, letters
Therapeutic change	Delegation, emotional contact	Reduced substance use, relational change	Emotional awakening, relief	Emotional integration
Redefinition of masculinity	"I do not have to carry everything"	"Help does not mean weakness"	"I am allowed to feel"	"I do not have to be flawless"

Legend: All vignettes are composite clinical constructions derived from recurrent therapeutic patterns observed across individual, group, and couple schema therapy with male patients. They do not correspond to identifiable individuals or specific treatment courses. Schema terminology follows Arntz *et al.*. (2021). Depression type classifications are descriptive and heuristic, not diagnostic. Abbreviations: EMS = Early Maladaptive Schema; ST = Schema Therapy.

masculinity, depressive symptomatology, and schema therapeutic change. Presenting the cases side by side allows clearer identification of transgenerational influences, dominant schemas and modes, and key mechanisms of therapeutic transformation. This comparison underscores how similar intrapsychic processes may emerge across diverse social contexts and life stages, while also illustrating the flexibility of schema therapy in addressing these variations (Table 1).

Commentary on the comparative table

The comparative analysis demonstrates that toxic masculinity does not present as a uniform clinical pattern. Instead, it adapts to social context, educational background, and developmental stage. Despite this variability, several consistent patterns emerge that are highly relevant for psychotherapeutic conceptualization and intervention.

A central finding across all vignettes is the role of transgenerational transmission of masculine norms. These norms appear either explicitly, as in war trauma, alcohol misuse, or physical toughness, or implicitly, as in intellectualization and performance orientation. They are rarely transmitted as conscious parenting strategies. Rather, they function as taken for granted rules of living. As a result, early maladaptive schemas develop not primarily through single traumatic events but through chronic frustration of core emotional needs.

The table also illustrates that depression in men shaped by toxic masculine norms can take multiple forms. These range from externalized and masked presentations to somatized and existential forms of depression. Despite these phenomenological differences, the intrapsychic core remains similar. Long term dominance of protective modes and sustained disconnection from the Vulnerable Child are central features. In this context, depression emerges not from emotional fragility but from the collapse of chronically overused adaptive strategies.

Another important observation concerns the social reinforcement of protective modes. Modes such as the Detached Protector and the Overcontroller are often rewarded through professional success, endurance, or rational competence. This reinforcement helps explain why men frequently seek therapy only at advanced stages of distress and why protective modes may initially resist therapeutic change.

Across all four cases, common mechanisms of therapeutic change can be identified. These include externalization of the Demanding Critic as a carrier of transgenerational norms, legitimization of protective strategies as originally adaptive responses, gradual access to the Vulnerable Child within a safe therapeutic relationship, and strengthening of the Healthy Adult together with a new definition of masculine identity. Change does not involve abandoning masculinity. It involves integrating and making it more flexible.

The comparison supports the clinical applicability of schema therapy in addressing toxic masculinity across diverse social and developmental contexts. It enables integration of social, developmental, and intrapsychic levels of understanding. It allows therapists to work with shame without pathologizing male identity. Finally, it offers men a narrative of change that preserves dignity while opening space for emotional connection, flexibility, and long-term psychological health.

DISCUSSION

The Contribution of Schema Therapy to Clinical Work with Toxic Masculinity

The clinical material presented here suggests that schema therapy provides a structured way to translate abstract discussions of masculinity into concrete therapeutic targets. Rather than treating toxic masculinity as a sociological label, the schema framework operationalizes it through identifiable schemas (e.g., emotional deprivation, unrelenting standards) and modes (e.g., Detached Protector, Demanding Critic) (Young *et al.* 2003; Arntz *et al.* 2021).

This operationalization is clinically relevant. It shifts the focus from debating masculinity as an ideology to identifying how specific internalized rules regulate affect and behavior in individual patients. In this model, toxic masculinity is not the primary pathology. It is a contextual amplifier of schema vulnerability.

Protective modes deserve particular attention. In many men, modes such as the Overcontroller or Detached Protector are socially rewarded for years. They support occupational success and emotional restraint. Therapy therefore confronts not overt dysfunction, but rigid overfunctioning. Depression often emerges only when these strategies become unsustainable.

Schema therapy addresses this dynamic directly. Instead of challenging masculinity as such, it differentiates between adaptive strength and rigid self-suppression. This distinction reduces defensiveness and facilitates access to vulnerable affect without framing it as weakness.

Comparison with CBT, Psychodynamic, and Gender-Sensitive Approaches

Standard cognitive-behavioral therapy effectively targets dysfunctional beliefs and behaviors. However, when masculine norms are deeply ego-syntonic, cognitive restructuring alone may reinforce intellectualization (Addis & Mahalik 2003). In such cases, experiential techniques become essential. Schema therapy integrates cognitive restructuring with imagery and chairwork, enabling work with shame and dissociated affect rather than only with explicit beliefs (Young *et al.* 2003; Arntz *et al.* 2021).

Psychodynamic approaches offer rich models of transference and intergenerational transmission. Yet they may provide less structured guidance for modifying entrenched coping modes. Schema therapy retains a developmental perspective while offering clearer intervention strategies, particularly for patients who struggle with emotional articulation.

Gender-sensitive therapies explicitly address masculine role expectations and are supported by empirical findings on help-seeking barriers (Seidler *et al.* 2016). Schema therapy complements this perspective by embedding gender norms within a broader developmental model. Instead of focusing solely on role critique or psychoeducation, it intervenes at the level of internalized self-evaluative systems.

Taken together, schema therapy functions less as an alternative to these approaches and more as an integrative framework that combines developmental depth, structured method, and cultural awareness.

Limitations of the Concept of Toxic Masculinity

Despite its heuristic value, the concept of toxic masculinity presents substantial conceptual and methodological challenges.

First, the term lacks consistent operational definition across disciplines. In gender studies, it often refers to hegemonic power structures. In clinical contexts, it is used more loosely to describe emotional restriction, dominance, or self-reliance (Connell & Messerschmidt 2005; Oliffe *et al.* 2012). This definitional variability complicates empirical measurement and increases the risk of construct drift. Without careful specification, the term may function more as a rhetorical device than as a clinically testable construct.

Second, there is a risk of circular reasoning. Behaviors such as emotional inhibition or avoidance of help-seeking are sometimes classified as manifestations of toxic masculinity. At the same time, these behaviors are used as evidence of its presence. Such formulations may obscure alternative explanations, including attachment history, trauma exposure, socioeconomic stress, or temperament.

Third, the construct may inadvertently homogenize male experience. Masculinity is not a unitary category. It varies across culture, class, generation, and sexual orientation (Connell 2005; Kimmel 2008). Applying the label "toxic" without contextual qualification may flatten these differences and obscure structural determinants of distress.

Fourth, some traits frequently grouped under toxic masculinity – such as persistence, emotional restraint in high-risk occupations, or tolerance of stress – may be adaptive in specific contexts (Mahalik *et al.* 2007). Pathologizing these traits without reference to situational demands risks overextension of the concept.

Finally, the present article relies on narrative synthesis and composite case material. The proposed schema-based operationalization remains a conceptual model rather than an empirically validated mechanism. Prospective and cross-cultural research is necessary to determine whether toxic masculinity functions as

an independent predictor of depressive outcomes or primarily as a moderator of pre-existing vulnerabilities.

For these reasons, toxic masculinity should be treated as a clinically useful but theoretically provisional construct. Its value lies in guiding formulation, not in replacing established diagnostic or developmental models (Mahalik *et al.* 2007).

Risks of Pathologizing Male Identity

The clinical use of the term toxic masculinity carries a non-trivial risk of unintended stigmatization. When employed imprecisely, the concept may blur the distinction between maladaptive coping strategies and male identity as such.

Men presenting with depression frequently report heightened sensitivity to perceived judgment and moral evaluation. (Kupers 2005; Vogel *et al.* 2011; Latalova *et al.* 2014). If therapeutic discourse frames certain gender-related behaviors as inherently "toxic," patients may experience this as a global devaluation rather than as an invitation to examine specific coping patterns. Such framing may inadvertently reinforce self-stigma and strengthen defensive modes, particularly the Detached Protector and Punitive Critic.

Moreover, there is a conceptual risk of reifying masculinity as a stable pathological category. From a developmental perspective, many behaviors associated with toxic masculinity—emotional restraint, self-reliance, endurance—emerge as adaptive responses within specific familial or socioeconomic contexts (Courtenay 2000; Mahalik *et al.* 2007); Pathologizing these adaptations without acknowledging their original function may undermine therapeutic alliance and obscure the developmental logic of the patient's coping system.

There is also a broader epistemic concern. Clinical constructs that carry strong normative connotations can drift from descriptive analysis toward moral categorization. When this occurs, the focus shifts from functional assessment to implicit value judgment. In psychotherapeutic settings, such shifts are particularly consequential because treatment engagement depends on perceived respect and safety.

For these reasons, clinicians should differentiate clearly between (a) rigid coping strategies that impair functioning and (b) masculinity as a multifaceted identity construct. Therapeutic work should target inflexibility, shame regulation, and schema-driven defenses rather than masculinity itself. This distinction preserves clinical precision while minimizing the risk of alienating the very population the construct seeks to help.

Cultural and Generational Differences

Expressions of masculine norms vary across generations and social contexts. Post-war cohorts were often shaped by endurance and emotional restraint, whereas younger men may experience pressures related to competitiveness and self-optimization (Kimmel 2008). These differences should inform individualized case formulation rather than broad generalizations. These differences directly influence the formation of schemas and modes. For example, post-war generations of men were often shaped by values of endurance and silence. Younger generations may instead face pressures related to performance, self-optimization, and competitiveness (Kimmel 2008).

CLINICAL IMPLICATIONS FOR PRACTICE

Framing Masculinity in Clinical Encounters

How masculinity is addressed in therapy has direct implications for alliance formation and treatment adherence. In men with high internalization of rigid masculine norms, evaluative or moralizing language may activate defensive modes and increase withdrawal (Vogel *et al.* 2011; Latalova *et al.* 2014). The issue is not semantic sensitivity alone but mode activation: framing distress as evidence of "toxic" identity may reinforce the Punitive Critic and strengthen Detached Protector functioning.

A more clinically precise approach is to focus on functional analysis rather than identity labeling. Masculinity-related behaviors should be conceptualized in terms of coping strategies, schema activation, and regulatory goals. This allows discussion of rigidity and cost without global identity threat. Such framing maintains alliance while permitting confrontation of maladaptive patterns.

Individual Therapy: Sequencing and Mode-Sensitive Intervention

In individual schema therapy, premature confrontation of vulnerability often escalates detachment or intellectualization. Initial phases should therefore prioritize stabilization of alliance and recognition of protective function. Protective modes in men with rigid masculine norms frequently have high ego-syntonic value and social reinforcement. Direct dismantling of these modes can produce reactance.

Experiential techniques such as imagery rescripting or chairwork become effective only after sufficient differentiation between the Punitive Critic, protective modes, and the Vulnerable Child has been established. Mode mapping is therefore not merely conceptual; it functions as a preparatory intervention that reduces fusion with self-critical narratives.

The therapeutic task is not to "encourage emotional expression" in abstract terms. It is to increase tolerance for affect activation without triggering shame-driven shutdown. This distinction is clinically decisive.

Group Therapy: Opportunities and Structural Risks

Group settings may provide corrective experiences through exposure to male peers who disclose vulnerability. However, without explicit structural containment, group processes can reproduce hierarchical or competitive masculine dynamics.

Schema mode language offers a regulatory tool in group contexts. Naming Detached Protector or Overcontroller activation in real time externalizes behavior and reduces personalization of conflict. This increases group cohesion and supports behavioral generalization.

Group interventions should therefore include explicit monitoring of dominance patterns and avoidance strategies rather than assuming that shared gender alone produces safety.

Couple and Family Interventions

In couple therapy, rigid masculine coping often manifests as emotional withdrawal rather than overt hostility. Interventions should focus on identifying reciprocal schema activation rather than attributing dysfunction to gendered personality traits.

When a partner's pursuit activates withdrawal, or criticism activates shame, the clinical target is the interactional schema loop. Reframing withdrawal as shame regulation rather than indifference can shift relational interpretation and reduce escalation.

In family contexts, interrupting transgenerational transmission requires more than psychoeducation. It involves modifying parental responses to children's affective expression in real time. This operational focus reduces the risk of abstract gender discourse detached from behavioral change.

Psychoeducation and Destigmatization: Scope and Limits

Psychoeducation about links between masculine norms, emotion regulation, and depression may reduce self-stigma in some patients (Latalova *et al.* 2014; Seidler *et al.* 2016). However, psychoeducation alone does not modify schema-driven defensive structures. Without experiential processing, insight remains cognitively contained and may even reinforce intellectualization.

Destigmatization should therefore be understood as a byproduct of experiential restructuring rather than as a primary intervention. When patients experience tolerated vulnerability within a corrective relational context, identity flexibility emerges organically.

Clinical practice should thus prioritize affect tolerance, mode differentiation, and relational restructuring over abstract redefinition of masculinity.

CONCLUSION

Toxic masculinity is best conceptualized as a modifiable pattern of internalized norms that, in interaction with developmental vulnerability, may contribute to depressive presentations in men. Within schema therapy, these norms can be translated into identifiable schemas and modes, enabling targeted experiential intervention. Clinical change does not require rejection of masculine identity but increased flexibility in its regulation. Future empirical studies should examine treatment outcomes in men with high internalization of rigid masculine norms and assess long-term modification of schema-driven coping patterns.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest related to this manuscript.

Use of Artificial Intelligence

Artificial intelligence (AI) tools (ChatGPT, OpenAI) were used exclusively for language editing and stylistic refinement of selected sections of the manuscript. All scientific content, conceptual interpretations, clinical analyses, and final editorial decisions were developed and critically reviewed by the authors. The authors take full responsibility for the integrity and accuracy of the manuscript.

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