Planned Statistical Analysis

- Compute theoretical YSQ-90 schema scale scores and theoretical SMI schema mode scale scores from available item-level data.
- Characterize the treatment-seeking clinical assessment sample dimensionally rather than diagnostically. Use available depression/anxiety totals and, after confirming the scoring key, C1-C90/SCL-90 symptom dimensions and/or global severity indices.
- Standardize profile indicators before latent profile modelling.
- Fit separate profile models for schema-only, mode-only, and combined schema+mode indicator sets.
- Compare candidate solutions across increasing profile numbers, expected initially across 2 to 6 profiles.
- Evaluate AIC, BIC, sample-size adjusted BIC/SABIC, entropy, LMR-LRT or adjusted LMR-LRT where available, BLRT where available, class sizes, visual profile plots, interpretability, parsimony, and clinical usefulness.
- Interpret selected profile solutions descriptively with reference to standard YSQ schema scales and SMI schema mode scales/categories; these categories will guide interpretation, not force model selection.
- Compare profile groups on depression, anxiety, and available SCL-90 dimensional symptom severity as external-validation analyses.
- Where feasible, examine external symptom variables using an approach that accounts for classification uncertainty, such as a three-step latent profile approach in a formal mixture-model workflow.
- Add secondary person-centered versus variable-centered comparisons: compare models using individual schema scores, individual mode scores, schema-profile membership, mode-profile membership, and combined schema+mode profile membership using explained variance, adjusted R^2, AIC/BIC, and cross-validated prediction error.
- Conduct sensitivity checks for nearby profile numbers, classification quality, complete-case outcome analyses, clinician/data-source adjustment if appropriate, and robustness of the profile-versus-individual-score comparisons.

The final preferred solution will not be selected solely by the lowest information criterion. The decision will balance statistical fit, classification quality, minimum class size, interpretability, clinical usefulness, and avoidance of redundant or unstable profiles. The study will not claim formal psychiatric diagnostic composition unless structured diagnostic data become available; symptom measures will be used for dimensional clinical characterization.