



The Impact of Schema Therapy on the Emotional Well-Being of Students from Divorced Families: A Mental Health Perspective

Parniyan Hooshmand Asadi¹, Giti Hemmati Rad^{1*}

1. Department of Psychology, Payam Noor University, Astara branch, Astara, Iran

*Corresponding

E-mail: g_hematirad@yahoo.com

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Abstract

Background and Objective: The existing literature shows that a child's failure to adapt to their parents' divorce can have devastating effects on their psychological and physical health. This research investigates the effectiveness of schema therapy in improving the emotional well-being of students from divorced families.

Methods: This quasi-experimental study utilized a pre-test/post-test design with a control group. The sample consisted of 30 female students aged 14–17 from Rasht whose parents were divorced. Participants were selected via convenience sampling and randomly assigned to either the experimental or control group, with 15 participants in each. Emotional well-being was assessed using the Emotional and Emotional Well-being Questionnaire by Keyes and Magyarmo (2003). The experimental group received schema therapy over 10 sessions of 45 minutes each, following the protocol developed by Young et al. (2003). Data were analyzed using Analysis of Covariance (ANCOVA) in SPSS version 26.

Findings: Schema therapy improved the quality of life and well-being of female students from divorced families by reducing feelings of loneliness, improving general health, and reducing rumination. Emotional well-being scores increased from 23.56 (SD = 7.48) to 48.12 (SD = 7.67), and flexibility scores improved from 49.64 (SD = 6.28) to 68.12 (SD = 5.23) following the intervention. These findings indicate that schema therapy significantly impacted both emotional well-being and psychological flexibility in the experimental group.

Conclusion: Emotional well-being can influence behavior and is manageable by the individual. Identifying and improving related issues—through methods like schema therapy—should be a key part of treatment.

Keywords: Mental health, Schema therapy, Divorce, Adolescent

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1. Introduction

Family is considered the most important social institution influencing the growth of children (1). Various factors within the family unit affect this process in different ways, with divorce being one of the most critical issues (2). Several studies have shown that the rising trend of divorce in the last half-century is a global phenomenon, resulting from economic, demographic, legal, cultural, and value changes (3). Statistics indicate that over a million children are sent to the child welfare system each year due to the divorce process (4). Approximately 10% of all children will experience parental divorce during their lifetime (5, 6). Parental divorce has various consequences, including emotional and psychological well-being (7).

Children from divorced families face more well-being challenges compared to children from intact families and are at a higher risk for psychological issues, which are influenced by their cognitions, attitudes, and beliefs (8, 9). Well-being is a complex construct linked to positive experiences and functioning. Emotional well-being is not simply the absence of psychiatric disorders, but rather refers to individuals' evaluation and perception of their life quality, including their social, psychological, and emotional functioning (10). Recent studies have pointed out that children of divorce experience emotions that can negatively impact their well-being and mental health (11, 12). Emotional well-being does not only refer to the presence of positive emotions and the absence of negative ones. A person might experience one of these components positively but still have poor emotional well-being. Therefore, these components are assessed separately. Children in divorced families, as one of the vulnerable groups in society, experience less-than-optimal emotional well-being due to parental separation (13).

Schema therapy has been reported to be a valuable tool for enhancing parenting skills and improving family relationships, including those affected by divorce (14). Schemata allow individuals to position themselves relative to time and meaningfully categorize and interpret experiences. The content of each schema is shaped and organized by personal life experiences and used in perceiving and evaluating new information (15). Schema therapy identifies and addresses maladaptive schemata and ineffective responses, replacing them with healthier thoughts and behaviors (16). Research has shown that schema therapy can lead to positive changes in cognitive, emotional, and behavioral aspects and help challenge maladaptive patterns while promoting better responses (17).

Specifically, schema therapy has been shown to reduce loneliness, increase general well-being, decrease rumination, and improve overall well-being in divorced women (18, 19). While the primary focus has been on the well-being of divorced women, schema therapy principles can be adapted to assist parents in identifying and meeting the unmet needs of their children, repairing relational gaps, and creating a more supportive environment for children of divorce (20, 21).

On the other hand, schema therapy is a psychological treatment that places significant emphasis on childhood experiences and personality pathology (22). According to Mirzayan and colleagues (2014), dysfunctional parental interactions are strong predictors of early maladaptive schemata and reduced interpersonal interactions in future relationships. Previous research has shown that schema therapy focuses on self-destructive thinking, feeling, and behavioral patterns rooted in childhood and repeated throughout a person's life (23, 24). Schemata are formed in childhood due to unmet needs for security and acceptance, adequacy and identity, freedom in expressing needs and healthy emotions, spontaneity and play, and self-control. As cognitive maladaptive schemata increase, the prevalence of certain disorders also increases, leading to decreased academic performance (25). Based on studies, it is evident that there is a relationship between early childhood experiences and the formation of early maladaptive schemata. These schemata are key factors in the hereditary-stress model of psychological disorders (26).

2. Objectives

Despite the recognized importance of schema therapy in mental health interventions, its impact on the emotional and psychological well-being of students from divorced families remains underexplored. This study aims to bridge this gap by evaluating the effectiveness of schema therapy in enhancing the mental well-being of these students, contributing to evidence-based approaches in child and adolescent mental health.

3. Methodology

The research employed a quasi-experimental, pre-test/post-test design with a control group. In this framework, the independent variable, schema therapy, was administered to the experimental group, while the control

group received no intervention. The dependent variables of interest were related to various measures of emotional well-being. All participants were assessed on these variables during a pre-test phase. Following the pre-test, participants were randomly assigned to either the experimental or control group. This randomization was crucial for ensuring initial equivalence between the groups, thereby minimizing the potential for confounding variables. After the intervention period, both groups completed a post-test to measure the same dependent variables. The study then used a statistical analysis to compare the change in scores between the two groups, which allowed for an evaluation of the intervention's effectiveness.

3.1. Study Population

The statistical population for this study was specifically limited to female students aged 14 to 17 years, whose parents were divorced and residing in Rasht, north of Iran. This target population was chosen based on the researchers' interest in investigating the effects of schema therapy intervention on the emotional well-being of this specific demographic group. A total of 30 participants were selected from this defined population. The selection of these 30 participants was based on two key criteria: an age range of 14 to 17 years and their current residence in Rasht. In addition, the researchers ensured that all 30 participants provided their consent and were willing to participate in the study. Once the participants were identified, they were randomly assigned to either the experimental group or the control group, with each group containing 15 participants. This random allocation was an important step in ensuring that the two groups were equivalent before the schema therapy intervention began. With an equal number of participants in each group, the researchers could more confidently attribute any observed differences in outcomes to the intervention effects.

3.2. Emotional and Psychological Well-being Questionnaire

In this study, the Mental Well-being Questionnaire developed by Keyes and Magyar-Moe (2003) was used to gather data on the emotional well-being and emotional variables of the participants. This questionnaire was selected due to its comprehensive assessment of emotional, psychological, and social well-being, which aligns well with the multifaceted nature of adolescent adjustment following parental divorce. Additionally, the tool has been previously

validated in Iranian populations, making it a culturally appropriate and psychometrically sound choice for this study.

The Mental Well-being Questionnaire consists of three main sections: emotional well-being (12 questions), psychological well-being (15 questions), and social well-being (15 questions). It was implemented and validated on a sample of 57 individuals (27). The validity and reliability of this questionnaire have previously been assessed (27, 28). The overall emotional well-being questionnaire showed a strong correlation coefficient of 0.78. The internal consistency and reliability of the questionnaire were found to be high, as indicated by the correlation coefficients of the subscales: emotional well-being ($r = 0.76$), psychological well-being ($r = 0.64$), and social well-being ($r = 0.76$). Further analysis of internal consistency was conducted using Cronbach's alpha. For the overall questionnaire, the internal consistency coefficient was 0.80. The subscale scores were as follows: emotional well-being ($\alpha = 0.86$), psychological well-being ($\alpha = 0.80$), and social well-being ($\alpha = 0.61$). These findings are consistent with prior research conducted by Ahmadi and colleagues in 2020, who reported an internal consistency coefficient of 0.63 for the overall questionnaire (28). The internal consistency coefficient based on Cronbach's alpha was 0.80 for the total questionnaire, and for its subscales, it was 0.86, 0.80, and 0.61, respectively. Ahmadi and colleagues reported an internal consistency coefficient based on Cronbach's alpha of 0.63 for the overall questionnaire and 0.25, 0.70, and 0.61 for the subscales (29). However, their subscale scores were slightly different: emotional well-being was 0.25, psychological well-being was 0.70, and social well-being was 0.61. To score the emotional well-being subscale, the researchers combined the scores for the positive emotions section (first 6 questions) and the negative emotions section (last 6 questions). It is important to note that all questions in the negative emotions section, except for question 5 in the emotional improvement scale, were reverse-coded before being added to the total score. This subscale was scored on a scale from 1 (not at all) to 5 (always), yielding a minimum possible score of 16 and a maximum of 56. The psychological well-being subscale had a score range from 18 to 126, while the social well-being subscale ranged from 15 to 105. The overall psychological well-being score was then computed by summing the scores of the emotional, psychological, and social well-being subscales (29) (Table 1).

Table 1. Scoring of the Emotional Well-being Questionnaire

Components	Questions
Emotional Correlation	1, 8, 12
Emotional Attachment	2, 6, 11
Emotional Acceptance and Approval	3, 10, 14
Emotional Engagement	4, 7, 15
Emotional Realism	13, 9, 5

In the emotional well-being section, questions 3, 4, 5, 6, 11, 12, and 14 were reverse-coded.

3.3. Intervention Method

Participants in the intervention group received an experimental treatment based on a schema therapy protocol developed by Young et al.(30). The schema therapy intervention took place over 10 group sessions, each lasting 45 minutes. The sessions were held three times a week, with the total intervention period lasting approximately 3-4 weeks. Table 2 presents the specific content and focus of each session

in the schema therapy intervention, providing an overview of the topics and activities covered throughout the 10 sessions. The intervention was structured with regular, long-term group sessions to provide the experimental group participants with a comprehensive schema therapy experience. This standardized approach allowed for a systematic evaluation of the impact of the intervention on the dependent variables of emotional well-being and emotional factors.

Table 2. Summary of Schema Therapy Session Content (30)

Session	Session Content
1	Introduction and relationship building, explaining the importance and goals of schema therapy, and identifying client issues.
2	Explaining the schema therapy approach, introduction to schemata, identification of early maladaptive schemata, and analyzing evidence supporting or refuting these schemata based on current and past life experiences.
3	Introduction to various domains of early maladaptive schemata and the use of the schema validity test technique, re-evaluating the benefits and disadvantages of coping styles.
4	Introduction to different maladaptive coping styles, schema mindset, helping with imagery and recalling memories, identifying unmet needs and releasing blocked emotions.
5	Conducting the Young questionnaire, preparing for schema acceptance and change, and providing feedback for further schema identification.
6	Using experiential techniques such as imagery for challenging situations and confronting the most problematic ones.
7	Teaching relational therapy and how to communicate with important people in life, through role-playing.
8	Teaching and practicing healthy behaviors, completing homework assignments, writing letters to parents, and learning new behavioral patterns.
9	Implementing behavioral pattern-breaking and analyzing the pros and cons of healthy vs. unhealthy behaviors, offering strategies to overcome barriers to behavioral change.
10	Reviewing previous sessions and practicing taught strategies.

3.4. Intervention Implementation

Following permission and coordination with local schools in Rasht, a sample of 30 female students (ages 14–17) who had experienced parental divorce was identified. Participants were selected using a convenience sampling method, as they were local students willing to take part in the study. These participants were then randomly assigned to one of two groups: an experimental group (n=15) or a control group (n=15). This random assignment helped to balance the groups and mitigate confounding factors, ensuring the groups were comparable at the outset. Before any intervention, both the experimental and control groups completed the emotional well-being and emotional variables questionnaires. Participant

consent and confidentiality of responses were emphasized to ensure honest and accurate data collection. Following the pre-intervention assessments, the experimental group began the group schema therapy program. The intervention took place over 10 sessions, held three times a week at one of the schools in Rasht. The sessions started in May and concluded by the end of June 2022. The control group, on the other hand, did not receive any intervention during this period. They continued with their regular activities without participation in the schema therapy program. Upon completion of the 10-session intervention, participants in the experimental group completed the emotional well-being and emotional variables questionnaires for the second time. This

post-intervention assessment allowed the researchers to evaluate any changes or improvements in the dependent variables by comparing them to the pre-intervention scores. Due to the intervention's nature, full blinding was not feasible. To mitigate potential bias, the researchers who conducted the assessments were distinct from the therapy providers, and participants were not informed of the study's expected outcomes to reduce expectancy effects.

3.5. Statistical Analysis

For data analysis, a combination of descriptive and inferential statistical techniques was used. Descriptive statistics, including means and standard deviations, were presented using frequency distribution tables. ANCOVA (Analysis of Covariance) was performed using SPSS-26 to determine the intervention's effect on emotional well-being and emotional variables after accounting for pre-existing group differences.

Table 3. ANCOVA on the Effectiveness of Schema Therapy in Components of Emotional and Affective Well-being

Source	Sum of Squares (SS)	Degrees of Freedom (df)	Mean Squares (MS)	F-statistic (F)	Significance Level (P)
Adjusted Model	6.059	2	3.029	16.211	0.000
Intercept	0.135	1	1.135	0.722	0.403
Pre-test	2.365	1	2.365	12.654	0.001
Group	6.019	1	6.019	32.2	0.000
Error	5.046	27	0.187	-	-
Total	524.561	30	-	-	-
Adjusted Total	11.105	29	-	-	-
R ²	0.522	Adjusted R ²	0.513		

4. Results

This study included 30 participants in total, split evenly between the experimental group (n=15) and the control group (n=15). The age distribution for the experimental group was 14-15 years (n=8), 15-16 years (n=4), and 16-17 years (n=3). In the control group, there were 6 participants aged 14-15, 5 aged 15-16, and 4 aged 16-17.

4.1. Emotional and Affective Well-being

In the experimental group that received schema therapy, the mean score for emotional well-being in the pre-test was 23.56 (SD = 7.48), which increased significantly to 48.12 (SD = 7.67) in the post-test. This suggests a notable improvement in emotional well-being following the intervention. In contrast, the control group showed minimal change, with a pre-test mean score of 25.12 (SD = 5.17) and a post-test mean of 25.23 (SD = 4.33). The scoring range for this variable was between 16 and 56, indicating that the post-test means in the experimental group approached the higher end of the scale.

Regarding the flexibility variable, the experimental group demonstrated a marked increase in scores from 49.64 (SD = 6.28) to 68.12 (SD = 5.23). This improvement reflects enhanced psychological flexibility among participants following schema therapy. In the control group, however, changes were minimal, with the pre-test mean score at 62.12 (SD = 7.60) and the post-test score at 63.28 (SD = 4.01). The

score range for this variable was 15 to 105, suggesting that while the control group remained relatively stable, the experimental group experienced substantial positive change.

4.2. Effect of Schema Therapy on Emotional and Affective Well-being

According to Table, schema therapy had a significant effect on the emotional and affective well-being of students from divorced families ($P < 0.05$). The model explains about 52% of the changes in well-being scores, meaning it fits the data well. Although the intercept was not significant, the pre-test scores were ($P = 0.001$), showing that students' initial well-being levels influenced their results after therapy. Also, there was a significant difference between the experimental and control groups ($P = 0.000$), indicating that schema therapy improved emotional and affective well-being. The remaining error shows the part of the variation that the model could not explain.

4.3. Effect of Schema Therapy on Affective Well-being

Table 4 focuses specifically on affective well-being. The results show that about 40% of the changes in affective well-being can be explained by the model (adjusted $R^2 = 0.40$). Since the significance level is less than 0.05, we can say with 95% confidence that schema therapy had a meaningful impact on affective well-being.

Table 4. ANCOVA on the Effectiveness of Schema Therapy in Affective Well-being

Source	SS	df	MS	F	P
Adjusted Model	30.067	1	15.034	135.77	0.000
Intercept	0.441	1	0.441	3.979	0.056
Pre-test	3.778	1	3.778	34.119	0.000
Group	27.217	1	27.217	245.8	0.000
Error	2.99	27	0.111	-	-
Total	881.951	30	-	-	-
Adjusted Total	33.057	29	-	-	-
R ²	0.41	Adjusted R ²	0.403		

4.4. Effect of Schema Therapy on Emotional Well-being

Table 5 analyzes emotional well-being separately. Here, the adjusted R² value is about 60%, meaning schema therapy accounts for more than half of the

differences observed in emotional well-being scores. The statistical significance ($P < 0.05$) confirms that schema therapy has a strong positive effect on the emotional well-being of students from divorced families.

Table 5. ANCOVA on the Effectiveness of Schema Therapy in Emotional Well-being

Source	SS	df	MS	F	P
Adjusted Model	10.876	2	5.438	22.162	0.000
Intercept	1.05	1	1.05	4.281	0.048
Pre-test	7.119	1	7.119	29.013	0.000
Group	6.458	1	6.458	26.319	0.000
Error	6.625	27	0.245	-	-
Total	763.672	30	-	-	-
Adjusted Total	17.501	29	-	-	-
R ²	0.621	Adjusted R ²	0.593		

5. Discussion

The findings of this study indicated that schema therapy could explain more than half of the variables related to emotional and affective well-being simultaneously. This effect is positive, as it leads to improvements in these two components, suggesting that the schema therapy approach has had a significant impact on enhancing these two important aspects of overall well-being. Thus, it can be inferred that emotional and affective well-being may influence an individual's behavior. Consequently, addressing and resolving issues related to these components through interventions like schema therapy should be an essential part of treatment (31). Sahour et al.'s study (2023) demonstrated that mindfulness-based schema therapy is effective in addressing maladaptive emotional schemata and promoting healthier emotional processing and expression (32). Similarly, Shayganmanesh et al. found that cognitive-behavioral interventions and schema therapy can improve aspects of multidimensional body image in individuals with social anxiety disorder (33). Additionally, Pourpashang et al.

reported that group schema therapy effectively enhances psychological well-being and resilience in individuals undergoing methadone and buprenorphine treatment (34).

Other findings indicated that schema therapy could influence approximately 40% of the emotional well-being of students from divorced families. This effect was positive, as shown by the pre-test mean score of 49.64 in the experimental group that received schema therapy, which increased to 68.12 in the post-test. This finding aligns with the studies of Mohammad Nezhady and Rabiei (35) and Sangani and Dasht Bozorgi (36). In this regard, it can be concluded that as emotional well-being issues increase, the prevalence of certain disorders also rises, which in turn leads to reduced academic performance. Schema therapy can influence emotional processing mechanisms and protect individuals from psychological harm. When schema therapy activates emotional well-being, it affects perception, reality, and emotional processing. The schema therapy approach is beneficial in modifying beliefs and thoughts, as it works on

individuals' psychological core—maladaptive early schemata, which often contribute to a negative self-view (37).

Mirabi et al. also showed that both emotion-focused schema therapy and short-term solution-focused therapy were effective in improving psychological well-being and action flexibility in women experiencing marital conflicts who sought psychological services. However, no significant difference was found between the effectiveness of the two treatments on psychological well-being and action flexibility. Therefore, emotion-focused schema therapy and short-term solution-focused therapy can be used to enhance psychological well-being and flexibility in these women (38). In the emotional dimension, schema therapy challenges cognitive beliefs linked to emotional beliefs through experiential strategies. This process helps individuals recognize unmet emotional needs that have led to the formation of maladaptive schemata through emotional catharsis (34). Additionally, behavioral techniques help increase motivation for behavior change and replace unhealthy behaviors with healthier ones, thereby assisting in modifying and improving schemata (39).

The results of our study showed that schema therapy could account for approximately 60% of the variation in emotional well-being. This effect was positive, as the pre-test mean score for the experimental group receiving schema therapy was 23.56, which nearly doubled in the post-test. This finding highlights the strong and significant impact of the intervention on this crucial aspect of mental well-being. The doubling of the emotional well-being score from pre-test to post-test in the experimental group emphasizes the effectiveness of schema therapy. Such a substantial improvement in emotional well-being is a highly desirable outcome. Thus, the schema therapy framework, with its focus on identifying and modifying maladaptive schemata, developing emotional regulation skills, and fostering self-compassion, appears to be a suitable approach for enhancing emotional well-being. The comprehensive nature of this approach likely contributes to its effectiveness. This finding is consistent with the studies of Shahab et al. and Moghanloo (40, 41).

Therefore, implementing schema therapy increases feelings of self-worth, competence, positivity, self-confidence, and personal growth. Eliminating or modifying maladaptive early schemata leads to changes in individuals' beliefs, thereby altering their self-perception and recognition of their inherent abilities, ultimately enhancing students' emotional well-being in education (42). Schemata influence students' behavior

through information processing, which assists in decision-making during cognitive processes. However, in some mental processes, schemata may act as a resistance factor against change, slowing down behavioral adaptation. The psychological impact of parental divorce is often intensified through loneliness, witnessing pre-divorce tensions, and distorted information processing, all of which can reduce emotional well-being. Thus, schema therapy can significantly improve the emotional well-being of female students with divorced parents (43, 44).

5.1. Limitations and Recommendations

It is essential to acknowledge that this study, like others, has certain limitations. The current research did not examine the economic and cultural backgrounds of the participants, which could influence the effectiveness of the intervention. Moreover, the study was limited to female students with divorced parents, so the findings may not be generalizable to male students. Since the research was conducted in Gilan Province, the results may not apply to other subcultures or regions. Another limitation is that schema therapy was not compared with other types of therapy, making it unclear whether it is more or less effective than alternative approaches. Future studies should address these limitations by including diverse participant groups, considering economic and cultural factors, using follow-up assessments, and comparing schema therapy with other therapeutic methods.

6. Conclusion

In this study, schema therapy was identified as an effective intervention for improving emotional well-being and flexibility in students from divorced families. The experimental group that received schema therapy showed significant improvement in these areas compared to the control group. Additionally, schema therapy explained a substantial portion of the variation in emotional well-being and flexibility, demonstrating the strong impact of the intervention. The main effect of the group indicated that schema therapy had a significant impact on emotional well-being and flexibility, confirming its effectiveness in enhancing these aspects among students from divorced families. These findings provide strong evidence for the effectiveness of schema therapy in increasing emotional well-being and flexibility in students from divorced families. They have important implications for developing targeted interventions to support the mental well-being of children and adolescents from divorced families.

Footnotes**Conflict of Interests Statement**

The authors declare that there is no conflict of interest regarding the present study.

Data Availability

All data generated or analyzed during this study will be available from the corresponding author on reasonable request.

Funding/Support

The present study received no funding/support.

Ethical Approval

This study was conducted based on survey data and involved no invasive procedures or medical interventions. Participation was entirely voluntary, and all participants provided informed consent before taking part in the study. Confidentiality and anonymity of the participants were strictly maintained throughout the research process. Given that this study was based on a survey and did not involve clinical interventions, it was not required to obtain ethics approval. However, all research procedures adhered to ethical guidelines for psychological studies and respected the rights and well-being of the participants.

Authors' Contribution

M. A. and R. J. F. developed the study concept and design. S. S. acquired the data. F. H. and A. F. analyzed and interpreted the data, and wrote the first draft of the manuscript. All authors contributed to the intellectual content, manuscript editing and read and approved the final manuscript. R. J. F. and S. S. provided administrative support.

Informed Consent

Written informed consent was obtained from all parents/guardians on behalf of participants under 18 years old, and written assent was obtained from all adolescent participants.

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