

# Protective and risk pathways between religiosity and early maladaptive schemas in adolescent mental health

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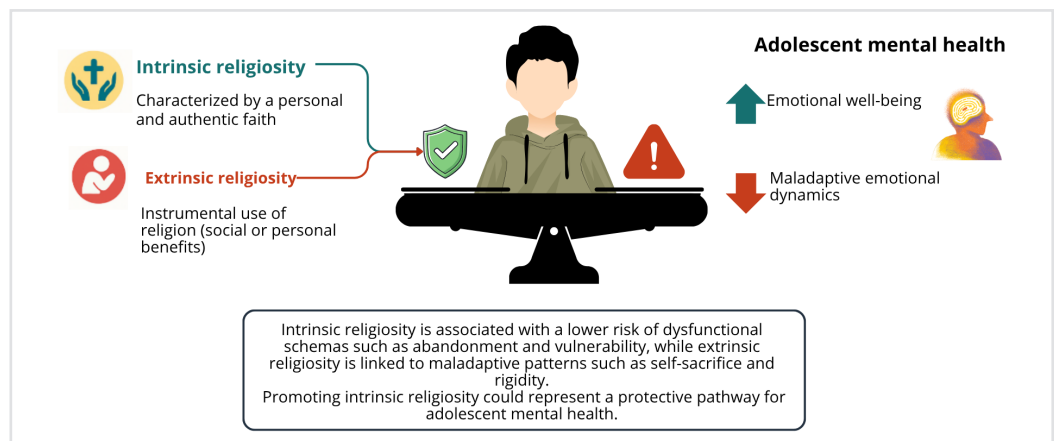
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## Highlights

- The study examined the relationship between religiosity and early maladaptive schemas (EMS) in 360 Peruvian students.
- A descriptive–correlational design was applied using the YSQ–SF and Age Universal I–E 12 Scale.
- Intrinsic religiosity was negatively associated with vulnerability to harm and illness and entitlement/grandiosity.
- Extrinsic religiosity correlated positively with self-sacrifice and unrelenting standards.
- Religiosity may act as both a protective and risk factor for adolescent emotional well-being.

## Graphical Abstract



## Abstract

Religiosity may be linked to psychological functioning, particularly in terms of coping strategies, emotional regulation and the development of cognitive-behavioural patterns. This study examined the relationship between dimensions of religiosity and early maladaptive schemas (EMS) using a quantitative, cross-sectional, descriptive-correlational design. The study involved 360 secondary school students from an educational institution in southern Peru, with a mean age of 15.6 years (SD = 1.05), selected using purposive non-probabilistic sampling. The Young Schema Questionnaire–Short Form (YSQ-SF) and the Age Universal I-E 12 Scale were used. Analyses were conducted using Spearman's rho. Intrinsic religiosity was negatively correlated with vulnerability to harm and illness ( $p = -0.452$ ;  $p < 0.001$ ) and entitlement/grandiosity ( $p = -0.151$ ;  $p = 0.004$ ), but not with abandonment ( $p = -0.095$ ;  $p = 0.071$ ). Extrinsic-social religiosity was positively associated with insufficient self-control/discipline ( $p = 0.220$ ;  $p < 0.001$ ), self-sacrifice ( $p = 0.240$ ;  $p < 0.001$ ), inflexible standards 2 ( $p = 0.153$ ;  $p = 0.004$ ) and emotional inhibition ( $p = 0.113$ ;  $p = 0.032$ ), and negatively with vulnerability to harm and illness ( $p = -0.206$ ;  $p < 0.001$ ). Extrinsic-personal religiosity was negatively correlated with mistrust/abuse ( $p = -0.114$ ;  $p = 0.031$ ), vulnerability to harm and illness ( $p = -0.220$ ;  $p < 0.001$ ) and inflexible standards 1 ( $p = -0.121$ ;  $p = 0.022$ ), and positively with self-sacrifice ( $p = 0.133$ ;  $p = 0.011$ ). These findings suggest that religiosity is differentially related to certain EMS, although due to the cross-sectional design it is not possible to establish causal relationships. It is recommended that religiosity be considered as a contextual factor in psychological assessment and educational guidance programmes.

**Keywords:** Religiosity. Cognitive Schemas. Adolescent Behavior. Mental Health. Stress.

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## INTRODUCTION

Mental health in the school population represents a priority within psychological research, as this stage shapes cognitive, emotional, and behavioral patterns that affect how students adapt socially. Among the cognitive structures that influence psychological functioning, Early Maladaptive Schemas (EMS) stand out as dysfunctional emotional and cognitive patterns that develop during childhood and significantly impact behavior and well-being throughout life<sup>1</sup>. These schemas may be related to religiosity, since religion constitutes a belief system internalized through social and cultural learning – often within family or church settings – which may reinforce or attenuate such schemas<sup>2</sup>. Religiosity is understood as a system of moral and social values and beliefs that forms part of personal identity and exerts a direct influence on human behavior<sup>3</sup>.

The prevalence of mental disorders such as anxiety and depression has increased considerably, affecting one in every eight individuals, and these conditions have been linked to EMS<sup>4</sup>. In Europe and Asia, for instance, schemas such as punitiveness and subjugation have been associated with anxious representations of God and with marital conflicts moderated by religiosity<sup>5</sup>. In contrast, Latin American studies have shown that EMS may increase aggressive behaviors and lower adolescents' academic performance or negatively affect psychological well-being<sup>6</sup>, particularly among younger students<sup>7,8</sup>. These schemas are present across age groups and contexts, with their prevalence varying according to cultural, academic, and social factors, although they are rarely entirely absent.

Previous research has examined the interaction between EMS and students' mental health, particularly in religious and academic contexts. Several studies have demonstrated that religiosity can act as a protective factor against mental health problems by enhancing psychological resources such as resilience and self-control, thus contributing to greater life satisfaction<sup>9,10</sup>. Young people who considered religious practice unimportant were more likely to experience emotional disorders, whereas regular attendance at religious services appeared to reduce this probability.

Nevertheless, other findings indicate that religiosity may also be associated with higher levels of internalized problems such as depression and self-harm ideation, especially among adolescents exposed to neglectful parenting styles or reconstituted families<sup>11</sup>. Within this framework, EMS provide an explanatory mechanism, as religious scrupulos-

ity has been linked to schemas of punitiveness, subjugation, and insufficiency, with pessimistic patterns assuming a central role and contributing to lower academic performance<sup>2,12</sup>. Furthermore, anxious–extrinsic religiosity tends to be associated with EMS, particularly with religious representations of a controlling or punitive God, whereas intrinsic religiosity is linked to affectionate and supportive parenting styles<sup>13</sup>. Although studies confirm a complex relationship between religiosity and EMS – acting both as protective and risk factors for mental health – further research is still needed to clarify these associations.

Despite scientific progress regarding both constructs, the literature remains scarce when attempting to establish a connection between them, particularly among students in basic education. Available evidence suggests that religiosity, depending on its orientation and style, may contribute to the consolidation of functional schemas or the reinforcement of dysfunctional ones<sup>14</sup>. This highlights the need for empirical studies addressing this relationship during the school years, when educational and family processes closely interact with religious experience. While religion aims to provide comfort and meaning, it may also generate anxiety and stress by imposing strict normative expectations, thus exacerbating feelings of guilt, shame, or even suicidal ideation<sup>15</sup>.

Religiosity encompasses beliefs and practices related to the sacred that offer a framework for life meaning and transcendence. It can be expressed as intrinsic religiosity, reflecting genuine and internalized faith guided by moral values, or as extrinsic religiosity, oriented toward external benefits such as social support or emotional security<sup>16</sup>. This construct significantly influences emotional regulation, promoting resilience and adaptive coping strategies in the face of adversity<sup>17</sup>. Religiosity can be structured into three orientations: intrinsic, where religion serves as a central guiding principle that integrates beliefs and behavior; extrinsic–social, which reinforces group belonging through rituals and shared practices; and extrinsic–personal, characterized by the instrumental use of religion to obtain comfort, existential security, or social recognition<sup>18</sup>.

Similarly, EMS are cognitive–emotional patterns formed in childhood that shape self-perception and interpersonal relationships<sup>1</sup>. They arise from unmet emotional needs and adverse experiences, producing long-term effects on coping and psychological

adjustment<sup>19</sup>. Consequently, they are associated with various mental health problems such as depression, anxiety, and maladaptive behaviors<sup>20</sup>. Schemas are grouped into five domains: disconnection and rejection, when individuals expect their needs for security and acceptance will not be met; impaired autonomy, involving dependency and incompetence in everyday functioning; impaired limits, characterized by difficulties in self-control and responsibility; other-directedness, which prioritizes others' needs over one's own; and over-responsibility and inhibition, marked by perfectionism and excessive emotional control<sup>1</sup>.

The relationship between religiosity and EMS can be further explained through three theoretical perspectives. The Early Maladaptive Schema Theory<sup>1</sup> posits that these schemas result from the frustration of basic emotional needs in childhood – such as safety, connection, and autonomy – and shape the individual's interpretation of the world and relationships. The Typological Theory of Religiosity<sup>16</sup> distinguishes between intrinsic religiosity, characterized by internalized belief and commitment, and extrinsic religiosity, focused on external rewards or social benefits. Finally, the Theory of Religiosity as a Coping Mechanism<sup>17</sup> argues that re-

ligiosity, whether intrinsic or extrinsic, can serve as a psychological resource for managing stress and finding meaning. More recent research integrates these frameworks, showing that intrinsic religiosity may buffer the negative effects of certain maladaptive schemas, whereas extrinsic religiosity – particularly when linked to a punitive image of the divine – may intensify them<sup>13</sup>.

In this context, the present study aims to analyze the relationship between religiosity and early maladaptive schemas in secondary school students, identifying how different religious orientations may influence cognitive and emotional functioning. Specifically, the research focuses on the schemas of abandonment, insufficient self-control/discipline, mistrust/abuse, emotional deprivation, vulnerability to harm and illness, self-sacrifice, unrelenting standards 1 and 2, emotional inhibition, entitlement, and enmeshment. Understanding this relationship may provide useful insights for the development of evidence-based psychotherapeutic and preventive interventions, considering that schema therapy has proven effective in addressing maladaptive cognitive patterns and promoting adolescents' emotional well-being.

## MATERIAL AND METHODS

### *Design*

The present study adopts a non-experimental design, as the research variables were not subject to manipulation. Likewise, it corresponds to a correlational level of research, since its objective was to determine the existence of a relationship between the two variables. Finally, it is classified as descriptive research, as it aims to describe the characteristics of the variables within the studied population<sup>21</sup>.

### *Sample*

The study comprised 360 secondary school students from an educational institution located in southern Peru. Purposive non-probabilistic sampling was used, as participants were selected according to pre-established criteria and based on their availability and accessibility within the educational institution. This made it possible to include students who met the necessary conditions to complete the assessment tools appropriately. It is worth noting that all students (402 students) were invited to participate in the research; however, due to the exclusion criteria, 42 students were not included.

The inclusion criteria were: (a) being enrolled at

the educational institution during the data collection period; (b) having informed consent signed by parents or legal guardians; (c) providing informed consent; and (d) completing all items in the assessment tools. Of the total participants, 51.66% were male and 48.33% female. The mean age was 15.6 years, with a standard deviation of 1.05 years; the minimum age recorded was 13 years and the maximum was 17 years.

### *Data collection instruments*

This study utilised an abbreviated version of the YSQ-SF validated for the Latin American context, which is operationalised into 11 EMS within a 45-item structure using a 6-point Likert scale, ranging from 1 (“does not apply to me at all”) to 6 (“describes me perfectly”)<sup>20</sup>. This is because the psychometric evidence available for the target cultural context supports this configuration of 11 schemas; the remaining schemas from Young's expanded model<sup>1</sup> were not assessed in the present study. However, it is suggested that future research consider the assessment of all schemas, should that be the objective. Regarding reliability, a Cronbach's alpha coefficient of 0.91 was obtained, indicating

high internal consistency. Furthermore, as part of the validation process, an exploratory factor analysis was carried out, which yielded a total explained variance of 65%.

Secondly, the Age Universal I-E 12 Scale, adapted to the Latin American context<sup>18</sup>, was employed. This instrument assesses levels of intrinsic and extrinsic religiosity through 12 items distributed across three subscales: intrinsic, extrinsic-personal, and extrinsic-social. Participants respond using a 5-point Likert scale ranging from 1 (“strongly disagree”) to 5 (“strongly agree”). The scale demonstrates high reliability: 0.88 for the intrinsic subscale, 0.79 for the extrinsic-personal subscale, and 0.87 for the extrinsic-social subscale. Regarding validity, it accounts for 70.3% of the total variance, and the obtained fit indices indicate excellent model fit: RMSEA = 0.057 (< 0.08), while incremental indices (NNFI, CFI, IFI) reached 0.97, well above the minimum acceptable threshold of 0.90. Finally, the adjusted chi-square ratio of Satorra-Bentler (S-B  $\chi^2/df$ ) was 1.76, reflecting adequate model parsimony, since values below 2 are considered indicative of good fit.

### **Statistical analysis**

For the data collection, a formal request was submitted to the management of the educational institution to obtain authorisation to administer the questionnaires in person. Once institutional permission had been granted, the dates and times for the administration were coordinated with the relevant authorities. Data collection took place in June 2024 using printed questionnaires, administered in classrooms under standardised conditions. Before responding, participants were informed of the general objective of the study, the voluntary

nature of their participation, the confidentiality of their responses, and the option to withdraw at any time without any consequences.

Once data collection was complete, descriptive statistics were calculated for the dimensions of religiosity (intrinsic, extrinsic-social and extrinsic-personal) and for each early maladaptive schema (EMS). Given the ordinal nature of the Likert-type responses and the possible deviation from normality, associations were analysed using Spearman’s correlation between each level of religiosity and the EMS scores. Effect sizes were interpreted using conventional criteria (small = 0.10, moderate = 0.30, large = 0.50). The significance level was set at  $\alpha = 0.05$  (two-tailed). P-values were reported as exact values and, where relevant,  $p < 0.001$  was considered significant. All analyses were performed using the Statistical Package for the Social Sciences (SPSS), version 25.

### **Ethical Considerations**

The research was conducted in accordance with the ethical principles set out in the Declaration of Helsinki and the provisions of the institutional code of ethics for research, approved by Resolution No. 162-2018. The anonymity and confidentiality of the information collected were guaranteed. Furthermore, written informed consent was obtained from parents or legal guardians, and informed assent was obtained from the students prior to the administration of the instruments. The principle of non-maleficence was respected, ensuring that the procedures did not cause physical or psychological harm. Furthermore, participants were explicitly informed of the academic and scientific use of the data, as well as their right to withdraw from the study at any time.

## **RESULTS**

Regarding religiosity, Table 1 presents the distribution of levels of religiosity and its three dimensions (intrinsic, extrinsic-social, and extrinsic-personal) in a sample of 360 secondary school students. With respect to overall religiosity, 43.33% of students were at a medium level, followed by 40.00% at a high level, and 16.67% at a low level. For intrinsic religiosity, 55.00% of participants were at a medium level, representing the majority, while 28.33% reported a high level and 16.67% a low level. This result indicates a moderate tendency toward an internalized religious experience. In the extrinsic-social religiosity dimension, 51.67% were at a medium level, 31.67% at a high level, and 16.67% at a low level. Finally, in the extrinsic-personal religios-

ity dimension, 51.67% of students were at a high level, 35.00% at a medium level, and only 13.33% at a low level.

Table 2 presents the descriptive distribution of the presence of EMS; the most prevalent schemas were emotional inhibition (63.33%), vulnerability to harm and illness (56.67%), and mistrust/abuse (51.67%). Furthermore, a predominant presence was observed in insufficient self-control/discipline and inflexible standards 1, both at 46.67%, followed by entitlement/grandiosity, at 45.00%, and self-sacrifice, at 43.33%. In contrast, the schemas with the lowest prevalence were inflexible standards 2, at 35.00%, fusion, at 36.67%, emotional deprivation, at 38.33%, and abandonment, at 25.00%.

**Table 1** - Levels of religiosity and its dimensions.

Variable	Low		Medium		High	
	n	%	n	%	n	%
Religiosity	60	16.67	156	43.33	144	40.00
Intrinsic religiosity	60	16.67	198	55.00	102	28.33
Extrinsic-social religiosity	60	16.67	186	51.67	114	31.67
Extrinsic-personal religiosity	48	13.33	126	35.00	186	51.67

**Table 2** - Significant presence of early maladaptive schemas and their dimensions.

Variable	No significant presence		Significant presence	
	n	%	n	%
Abandonment	270	75.00	90	25.00
Insufficient self-control/discipline	192	53.33	168	46.67
Mistrust/abuse	174	48.33	186	51.67
Emotional deprivation	222	61.67	138	38.33
Vulnerability to harm and illness	156	43.33	204	56.67
Self-sacrifice	204	56.67	156	43.33
Unrelenting standards 1	192	53.33	168	46.67
Unrelenting standards 2	234	65.00	126	35.00
Emotional inhibition	132	36.67	228	63.33
Entitlement	198	55.00	162	45.00
Enmeshment	228	63.33	132	36.67

Similarly, Table 3 presents the descriptive distribution of the predominant EMS according to overall levels of religiosity. It was observed that, within the group with high religiosity, the highest frequencies corresponded to the schemas of insufficient self-control/discipline, mistrust/abuse and emotional inhibition. In

contrast, in the group with low religiosity, higher relative proportions were identified in the schemas of emotional deprivation and fusion. These results should be interpreted solely in descriptive terms, as they do not constitute inferential evidence of statistical association.

**Table 3** - Relationship Between Levels of Religiosity and Predominant Early Maladaptive Schemas.

Predominant early maladaptive schemas	Low		Medium		High		Total	
	n	%	n	%	n	%	n	%
Abandonment	4	9.52	20	47.62	18	42.86	42	100.00
Insufficient self-control/discipline	3	8.33	14	38.89	19	52.78	36	100.00
Mistrust/abuse	1	5.56	9	50.00	8	44.44	18	100.00
Emotional deprivation	11	22.92	24	50.00	13	27.08	48	100.00
Vulnerability to harm and illness	8	22.22	17	47.22	11	30.56	36	100.00
Self-sacrifice	3	25.00	4	33.33	5	41.67	12	100.00
Unrelenting standards 1	10	18.52	23	42.59	21	38.89	54	100.00
Unrelenting standards 2	0	0.00	9	50.00	9	50.00	18	100.00
Emotional inhibition	9	21.43	14	33.33	19	45.24	42	100.00
Entitlement	4	13.33	14	46.67	12	40.00	30	100.00
Enmeshment	7	29.17	8	33.33	9	37.50	24	100.00
Total	60	16.67	156	43.33	144	40.00	360	100.00

With regard to the correlation between religiosity and EMS, as presented in Table 4, Spearman's rho correlation coefficient was applied, taking into account the ordinal nature of the scores obtained using Likert-type scales. The results showed statistically significant correlations between religiosity and the schemas of insufficient self-control/discipline ( $\rho = 0.172$ ;  $p = 0.001$ ), emotional deprivation ( $\rho = 0.144$ ;  $p = 0.006$ ), vulnerability to harm and illness ( $\rho = -0.316$ ;  $p < 0.001$ ), self-sacrifice ( $\rho = 0.202$ ;  $p < 0.001$ ), inflexible standards 1 ( $\rho = -0.151$ ;  $p = 0.004$ ) and emotional

inhibition ( $\rho = 0.110$ ;  $p = 0.036$ ). These associations were of weak magnitude, except for the relationship between religiosity and vulnerability to harm and illness, which was of moderate magnitude and negative direction. In contrast, no statistically significant correlations were observed between religiosity and the abandonment ( $\rho = 0.039$ ;  $p = 0.466$ ), mistrust/abuse ( $\rho = -0.038$ ;  $p = 0.477$ ), inflexible standards 2 ( $\rho = -0.026$ ;  $p = 0.619$ ), entitlement/grandiosity ( $\rho = -0.046$ ;  $p = 0.383$ ) and fusion/entrapment ( $\rho = 0.037$ ;  $p = 0.486$ ).

**Table 4** - Correlations between dimensions of early maladaptive schemas and religiosity.

Early maladaptive schemas	n	Rho ( $\rho$ )	p
Abandonment	360	0.039	0.466
Insufficient self-control/discipline	360	0.172	0.001
Mistrust/abuse	360	-0.038	0.477
Emotional deprivation	360	0.144	0.006
Vulnerability to harm and illness	360	-0.316	<0.001
Self-sacrifice	360	0.202	<0.001
Unrelenting standards 1	360	-0.151	0.004
Unrelenting standards 2	360	-0.026	0.619
Emotional inhibition	360	0.110	0.036
Entitlement	360	-0.046	0.383
Enmeshment	360	0.037	0.486

Finally, Table 5 presents the Spearman's rho correlations between the dimensions of religiosity and EMS. Intrinsic religiosity showed a negative and statistically significant correlation with vulnerability to harm and illness ( $\rho = -0.452$ ;  $p < 0.001$ ), of moderate magnitude, as well as a weak negative correlation with the entitlement/grandiosity schema ( $\rho = -0.151$ ;  $p = 0.004$ ). Meanwhile, extrinsic-social religiosity correlated positively and significantly with insufficient self-control/discipline ( $\rho = 0.220$ ;  $p < 0.001$ ), self-sacrifice ( $\rho = 0.240$ ;  $p < 0.001$ ), inflexible standards 2 ( $\rho = 0.153$ ;  $p = 0.004$ ) and emotional inhibition ( $\rho = 0.113$ ;  $p = 0.032$ ), whilst showing a significant negative correlation with vulnerability to

harm and illness ( $\rho = -0.206$ ;  $p < 0.001$ ). Finally, extrinsic-personal religiosity was negatively associated with mistrust/abuse ( $\rho = -0.114$ ;  $p = 0.031$ ), vulnerability to harm and illness ( $\rho = -0.220$ ;  $p < 0.001$ ) and inflexible standards 1 ( $\rho = -0.121$ ;  $p = 0.022$ ), and positively with self-sacrifice ( $\rho = 0.133$ ;  $p = 0.011$ ). In contrast, the schemas of abandonment, emotional deprivation and fusion did not show statistically significant correlations with any of the dimensions of religiosity assessed. Overall, the associations observed were of weak magnitude, except for the relationship between intrinsic religiosity and vulnerability to harm and illness, which reached a moderate magnitude.

**Table 5** - Correlations between the dimensions of early maladaptive schemas and the dimensions of religiosity.

Early maladaptive schemas	Intrinsic religiosity		Extrinsic-social religiosity		Extrinsic-personal religiosity	
	rho	p	rho	p	rho	p
Abandonment	-0.095	0.071	-0.021	0.694	-0.048	0.364
Insufficient self-control/discipline	0.042	0.428	0.220	<0.001	0.083	0.115
Mistrust/abuse	-0.080	0.128	0.060	0.253	-0.114	0.031
Emotional deprivation	-0.036	0.492	0.076	0.149	0.009	0.868
Vulnerability to harm and illness	-0.452	<0.001	-0.206	<0.001	-0.220	<0.001
Self-sacrifice	0.050	0.347	0.240	<0.001	0.133	0.011
Unrelenting standards 1	-0.058	0.272	0.036	0.495	-0.121	0.022
Unrelenting standards 2	0.091	0.085	0.153	0.004	0.002	0.966
Emotional inhibition	-0.027	0.614	0.113	0.032	0.081	0.127
Entitlement	-0.151	0.004	0.002	0.968	0.015	0.777
Enmeshment	-0.037	0.488	-0.068	0.197	0.034	0.517

## DISCUSSION

The overall analysis of the study showed that religiosity was statistically significantly correlated with certain EMS in secondary school students; however, these associations were not consistent across all the schemas assessed. When considering the overall religiosity score, significant correlations were observed with insufficient self-control/discipline, emotional deprivation, vulnerability to harm and illness, self-sacrifice, inflexible standards 1 and emotional inhibition. However, the analysis by dimension allowed for a clearer understanding that the relationship between religiosity and EMS varies according to the type of religious orientation assessed. This finding reflects the multidimensional nature of religiosity and aligns with the need, highlighted in recent reviews, not to reduce it solely to religious attendance or affiliation, but to consider its psychological, social and personal functions<sup>22</sup>. In this regard, the results suggest that religiosity is not uniformly related to all constructs, but rather exhibits differential patterns depending on whether it is intrinsic, extrinsic-social or extrinsic-personal in orientation.

These findings are partially consistent with the existing literature, which has indicated that religiosity and spirituality may be related to adolescent mental health, life satisfaction, psychological resilience and a sense of purpose<sup>9,10,22,23</sup>. However, there is also evidence that some forms of religious experience may be associated with psychological distress when linked to guilt, fear, spiritual conflict or negative religious coping<sup>22</sup>. Therefore, the data from the present study should be interpreted with caution, as the cross-sectional and correlational design does not allow for the establishment of causal relationships or the assertion that religiosity

acts directly as a protective or risk factor. Rather, the findings provide empirical evidence regarding specific associations between certain dimensions of religiosity and specific cognitive-emotional patterns.

Drawing on the theory of EMS, Young<sup>1</sup> argues that these are formed through repeated early experiences, particularly when basic emotional needs have not been adequately met. Within this framework, religiosity can be understood as a contextual factor that interacts with family, educational and sociocultural processes. Furthermore, recent literature has highlighted that spirituality and religiosity can serve as sources of coping, social support, purpose and resilience for adolescents and families in vulnerable contexts<sup>23</sup>. This perspective allows the findings of the present study to be interpreted without assuming that religiosity is inherently positive or negative, but rather as a complex experience whose association with EMS depends on the way in which it is internalised and experienced.

One of the most consistent findings was the negative correlation between the three dimensions of religiosity and the vulnerability to harm and illness construct. The association was strongest with intrinsic religiosity ( $\rho = -0.452$ ;  $p < 0.001$ ), followed by extrinsic-personal religiosity ( $\rho = -0.220$ ;  $p < 0.001$ ) and extrinsic-social religiosity ( $\rho = -0.206$ ;  $p < 0.001$ ). This pattern suggests that, in the sample studied, higher levels of religiosity were associated with lower scores on the schema characterised by exaggerated anticipation of catastrophes, illness or harm. Theoretically, this result can be interpreted in terms of the function of religiosity as a source of meaning, existential security and coping with uncertainty<sup>17,22,23,24</sup>. In particular, intrinsic

religiosity, being more closely linked to a personal and internalised experience of faith, could be related to a greater perception of emotional security. However, this interpretation should be understood in associative rather than causal terms.

Intrinsic religiosity also showed a weak negative correlation with the entitlement/grandiosity schema ( $\rho = -0.151$ ;  $p = 0.004$ ). This finding suggests that a more internalised religious experience may be associated with a lower tendency towards beliefs of superiority, privilege, or difficulty in recognising interpersonal boundaries. This interpretation is consistent with classical approaches to intrinsic religiosity, according to which religion is integrated as a life orientation and not merely as a means to obtain external benefits<sup>16</sup>. Furthermore, recent studies have indicated that intrinsic religiosity may be related to psychological well-being through mediating variables such as a sense of life purpose, emotional support and the integration of personal values<sup>25,26</sup>. However, due to the low magnitude of the correlation, the result should be interpreted with caution.

With regard to extrinsic-social religiosity, positive correlations were observed with insufficient self-control/discipline ( $\rho = 0.220$ ;  $p < 0.001$ ), self-sacrifice ( $\rho = 0.240$ ;  $p < 0.001$ ), inflexible standards 2 ( $\rho = 0.153$ ;  $p = 0.004$ ) and emotional inhibition ( $\rho = 0.113$ ;  $p = 0.032$ ), as well as a negative correlation with vulnerability to harm and illness. This pattern suggests that the social dimension of religiosity may coexist with certain patterns linked to behavioural regulation, other-orientatedness, emotional control and external demands. In particular, the association with insufficient self-control/discipline should be interpreted with caution, as it contrasts with previous evidence linking religiosity to higher levels of self-control and self-regulation<sup>27</sup>. One possible explanation is that extrinsic-social religiosity is more closely related to group membership, social approval or external normative compliance than to internal processes of personal regulation. Furthermore, extrinsic-social religiosity is characterised by the use of religion as a means of belonging, interaction or group integration<sup>16,25</sup>. In adolescents, this orientation could be associated with the search for approval, community belonging or conformity to shared norms, which would explain its link to self-sacrifice, emotional inhibition and certain interpersonal standards. However, these correlations were weak; therefore, it should not be assumed that social religious participation generates such patterns, but rather that both phenomena may coexist within certain family, school or community contexts.

The positive correlation between extrinsic-social religiosity and self-sacrifice is particularly significant. From a schema theory perspective, self-sacrifice im-

plies a tendency to excessively prioritise the needs of others over one's own<sup>1</sup>. In religious contexts, pro-social norms, helping others and community service can constitute adaptive resources; however, when these are rigidly internalised or associated with guilt, they may encourage patterns of excessive personal self-denial. The literature has described religiosity as a source of social support and coping<sup>23,24,28,29</sup>, but also cautions that religious experiences must be differentiated according to their psychological and relational function<sup>22,25</sup>. Consequently, the finding should not be interpreted as evidence of risk in itself, but rather as a sign that some forms of social religiosity may be associated with styles of other-directedness that require contextualised clinical assessment.

For its part, extrinsic-personal religiosity was negatively correlated with mistrust/abuse ( $\rho = -0.114$ ;  $p = 0.031$ ), vulnerability to harm and illness ( $\rho = -0.220$ ;  $p < 0.001$ ) and inflexible standards 1 ( $\rho = -0.121$ ;  $p = 0.022$ ), and positively with self-sacrifice ( $\rho = 0.133$ ;  $p = 0.011$ ). This dimension is linked to the use of religion as a source of comfort, relief, peace or personal security in the face of difficulties<sup>25</sup>. In this regard, the negative association with vulnerability and mistrust/abuse could indicate that those who turn to religiosity for personal support tend to exhibit lower levels of perceived threat or expectation of interpersonal harm. In turn, the negative correlation with inflexible standards suggests that this form of religiosity may be associated with lower levels of rigid self-demand. However, the positive correlation with self-sacrifice shows that this search for personal comfort can also coexist with a tendency to prioritise the needs of others, possibly as part of religious values of devotion, service or moral responsibility.

With regard to emotional deprivation, although overall religiosity showed a weak positive correlation, none of the three dimensions of religiosity demonstrated a statistically significant association with this construct. This finding suggests that the relationship observed at the overall level may be non-specific and not clearly attributable to any particular religious orientation. From Young's perspective<sup>1</sup>, emotional deprivation is linked to early experiences of a lack of care, empathy or emotional protection. Similarly, reviews of schemas in adolescents have shown that EMS are associated with experiences of abuse, neglect and early attachment difficulties<sup>30</sup>. Therefore, it is possible that emotional deprivation depends more on the quality of family and attachment bonds than on religiosity itself.

Furthermore, no significant correlations were found between any dimension of religiosity and the abandonment and fusion schemas. This finding is important because it corrects previous interpretations of the manuscript that suggested an association between

religiosity and abandonment. The current results indicate that there is insufficient statistical evidence to affirm such a relationship. According to Young's model<sup>1</sup>, abandonment is related to the perception of instability or lack of availability of significant figures, whilst fusion involves excessive emotional involvement with others, generally to the detriment of autonomy. Both schemas appear to be more closely linked to early family dynamics, attachment, overprotection or emotional dependence than to the dimensions of religiosity assessed<sup>31</sup>. This interpretation is consistent with recent evidence suggesting that maladaptive schemas in adolescents are strongly related to early experiences of abuse, neglect and emotional deprivation<sup>30</sup>.

Overall, the findings show that religiosity is associated with different patterns of EMS depending on its orientation. Intrinsic religiosity was primarily linked to lower vulnerability to harm and lower entitlement/grandiosity. Extrinsic-social religiosity was associated with greater self-control/poor discipline, self-sacrifice, inflexible standards and emotional inhibition, as well as lower vulnerability. Extrinsic-personal religiosity was associated with lower mistrust/abuse, lower vulnerability, lower self-imposed rigidity and higher self-sacrifice. These results suggest that religiosity should not be interpreted as a homogeneous construct, but rather as a multidimensional variable whose relationship with schemas depends on the psychological function it fulfils in the adolescent's life.

From a theoretical perspective, the findings align with Young's theory of EMS<sup>1</sup>, in that they show that certain cognitive-emotional patterns may be related to sociocultural variables such as religiosity. Furthermore, they reinforce the relevance of Allport and Ross's typological theory of religiosity<sup>16</sup>, given that the intrinsic, extrinsic-social and extrinsic-personal dimensions showed distinct correlational patterns. They are also related to the theory of religiosity as a coping mechanism<sup>17,32,33,34</sup>, as some associations, particularly those observed with vulnerability to harm and illness, suggest that religiosity may be linked to mechanisms of safety, comfort, support and meaning. However, the results also show that certain forms of religiosity, particularly

the extrinsic-social dimension, can coexist with patterns such as self-sacrifice, emotional inhibition or rigid interpersonal standards<sup>35</sup>, which prevents religiosity from being interpreted solely as a protective resource.

The practical implications of this study highlight the need for mental health and education professionals to consider religious experience as a relevant contextual factor in the psychological assessment of adolescents. However, such assessments must be conducted without simplistically assuming that religiosity is necessarily protective or harmful. From a clinical perspective, integrating the spiritual dimension can help to understand how adolescents organise their beliefs, cope with distress and construct personal meanings. Furthermore, the findings suggest the desirability of promoting educational and religious spaces centred on compassion, self-care, emotional autonomy and moral dialogue, whilst avoiding discourses that reinforce guilt, fear, excessive self-demand or rigid personal sacrifice<sup>36</sup>.

The main limitation of this study lies in its cross-sectional and correlational design, which prevents the establishment of causal relationships between religiosity and EMS. Furthermore, the use of self-report measures may have introduced social desirability bias, given the sensitivity of the topics addressed. The sample was restricted to students from a specific region of Peru, which limits the generalisation of the findings to other cultural, educational or religious contexts. In addition, although specific dimensions of religiosity were analysed, mediating or moderating variables such as parenting practices, family climate, type of religious education, religious denomination, perceived social support or the quality of the bond with religious figures were not incorporated. Future research should employ longitudinal designs and mixed-methods approaches to examine the direction of these associations and gain a deeper understanding of how religiosity interacts with family and cognitive-emotional processes during adolescence. Likewise, models should incorporate other relevant variables such as technology use, impulsivity or other indicators of mental health, enabling the assessment of complex risk models alongside religiosity and adaptive coping strategies<sup>37</sup>.

## CONCLUSION

The study concludes that religiosity is significantly associated with certain EMS, providing relevant empirical evidence in a field that remains largely unexplored in the national context. The results show that this relationship is not uniform, but varies depending on the dimension of religiosity assessed. Intrinsic religiosity was negatively associated with vulnerability to harm and illness and entitlement/grandiosity; extrinsic-social reli-

giosity was positively associated with insufficient self-control/discipline, self-sacrifice, inflexible standards 2 and emotional inhibition, and negatively associated with vulnerability to harm and illness; whilst extrinsic-personal religiosity was negatively associated with mistrust/abuse, vulnerability to harm and illness, and inflexible standards 1, and positively associated with self-sacrifice. In contrast, abandonment, emotional deprivation and fusion

did not show significant associations. Taken together, these findings suggest that religiosity constitutes a relevant contextual factor, although it should not be interpreted as exclusively protective or risky. Finally, the need to consider it in prevention pro-

grammes, educational guidance and psychological assessment is highlighted, promoting approaches centred on self-care, emotional regulation and well-being, without reinforcing guilt, fear, rigidity or excessive sacrifice.

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### Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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