Psychiatria Danubina, 2024; Vol. 36, No. 3-4, pp 300-309 https://doi.org/10.24869/psyd.2024.300 *Review article*

COMPARISON OF VARIOUS PSYCHOLOGICAL HUMAN NEED MODELS WITH SCHEMA THERAPY

John P. Louis[1], George Lockwood[2] & Karen M. Louis[3]

1 UCSI University Kuala Lumpur (South Wing)|Sarawak|Terengganu, Malaysia
2 Schema Therapy Institute Midwest, Kalamazoo, MI, USA
3 Louis Counselling & Training Services Pte. Ltd., Singapore

received: 11. 10. 2023; revised: 20. 1. 2024; accepted: 23. 1. 2024

Summary

Background*: Several theories have been proposed over the last few decades on identifying various fundamental psychological human needs. These theories were compared to a more recent theory using concepts from a fast growing form of psychotherapy called schema therapy. The empirical basis of the model from schema therapy was provided using Eastern and Western samples. Points of overlapp with the other models and schema therapy were discussed.*

Subjects and methods*: The model of needs from schema therapy was based on work conducted by principal author in 2020 using samples from Eastern (Singapore n=628; Kuala Lumpur, n=229), and Western countries (United States, n=214).*

Results*: Four separate categories consisting of the 14 Early Adaptive Schemas (positive schemas) were identified. Each group or positive schema domain represents a core emotional need that was adequately met, and these four were used as the basis for human psychological need from the vantage point of schema therapy.*

Conclusion*: All models of human needs were examined and compared with one another with special focus on constructs that had overlapped. Some models did not begin with infancy. However, there were definite points of convergence showing support for basic concepts of human psychological needs that were theorized over the last few decades, and its congruence with the model from schema therapy.*

Keywords: *human needs; schema therapy; core emotional needs; schemas; well-being; parents*

* * * * *

COMPARISON OF VARIOUS PSYCHOLOGICAL HUMAN NEED MODELS WITH SCHEMA THERAPY

In the wake of World War II, clinical psychology was focused on improving health and well-being by alleviating distress, especially as it related to trauma (Wood & Johnson, 2016). No doubt, such attention was valuable and essential. However, over time, an over-focus on distress and dysfunction took place, and eventually became the main source of enquiry during treatment in clinical psychology. This persisted to the latter part of the twentieth century until the then American Psychological Association President Martin Seligman introduced positive psychology (Seligman, 2002). Thousands of studies on positive psychology ensued (Wood & Johnson, 2016). While treatment on "what's wrong" in clinical psychology, and the use of one's "strengths" in positive psychology brought untold benefits to health and well-being, explorations of the basic human needs linked to dysfunction and well-being were not pursued with the same tenacity. If the root cause of much human dysfunction, specifically mental illness, is associated with unmet psychological needs, then identifying these needs should be made a priority. If these needs are deep structures that exert a strong influence on one's functioning, as schema therapy hypothesizes, then a focus on meeting them has the potential of providing more leverage for a deeper level of change and greater facilitation of optimal functioning.

A search of the history of the theories concerning human psychological needs was done through Google Scholar and the words used were "human psychological needs". This led to the identification of the major theories and an illucidation of their evolution over several decades. The identification of needs from the vantage point of schema therapy was based on empirical studies done by the authors (Louis et al., 2018; Louis et al., 2022; Louis et al., 2020), as well as others (Young et al., 2003; Hoffart et al., 2005; Bach et al., 2018). This model rests on an initial hypothesis put forward by Young et al (2003) that the development of each EMS is a result of a specific core emotional need not being met adequately by early caregivers. A later developing hypothesis made by Lockwood and Perris (2012) is that an EAS forms as a result of a specific core emotional need being met optimally or at least adequately (Lockwood & Perris, 2012). The identification of 18 EMSs (Young et al., 2003) and 14 EASs (Louis et al., 2018) provided two empirically

based frameworks coming from opposite developmental outcomes for working backwards to the identification of early core needs. Working with the two taxonomies, the authors (Louis et al., 2022, Louis et al., 2020), as well as others (Hoffart et al., 2005; Bach et al., 2018), performed further analyses of the 14 EASs and 18 EMSs and found there was a consistent pattern of four groupings for both that were virtually parallel to each other (Hoffart et al., 2005; Bach et al., 2018; Louis et al., 2020). Each grouping of EMSs is seen as defining a more general unmet need while the four categories of EASs, likewise, are seen as representing four broad needs that facilitate the development of EASs. These needs were termed core emotional needs (Young et al., 2003). It is these four core emotional needs that are being compared with other theories of psychological needs that have evolved over the past few decades in this paper. However, there has been a lack of focus in literature on human psychological needs compared to psychotherapeutic approaches that focus primarily on correcting one's unhealthy thinking, irrational thoughts, and or decreasing negative symptoms associated with an illness.

Therefore, the first aim of this paper is to provide an overview of the current models of psychological needs and compare these with the model that was conceptualized by Young et al., (2003) and empirically supported by the work of the authors (Louis et al., 2018; Louis et al., 2022; Louis et al., 2020) and backed up by decades of clinical work done by schema therapists. The latter is rooted in a rapidly growing empirical base for both schema therapy treatment and theory. The second aim of this paper is to show the greater empirical support towards the four groupings of both negative and positive schemas believed to represent the four core emotional needs in childhood, rather than the five as theorized by Young et al., (2003).

The term "need" is loosely used today in our everyday language: children say they need an ice-cream cone, college students say they need a new car, and parents of young children always say they need more sleep. The word "need" must be distinguished from the word "want"; the latter is defined (Cambridge University Press, 2023) as "to wish for a particular thing or plan or action". The former has several meanings, one being, "someone would get an advantage from having it" (Cambridge University Press, 2023). While the definition of physical needs, such as for food, water, and clothing, are universally accepted and understood, psychological needs – having no material existence and being mental or psychological in nature – are not as clearly understood and certainly not universally accepted (Deckers, 2018). Baumeister and Leary (1995) put forward a set of criteria on what qualifies as a fundamental psychological need: needs should produce effects readily under all adverse conditions, have affective qualities, direct cognitive processing, lead to ill-effect when thwarted, elicit goal-oriented behavior, be universal, not be derivative of other motives, affect a broad variety of behaviors and have implications that go beyond immediate psychological functioning. Two decades later, Dwek put forward the criteria that a fundamental psychological human need should not be able to be reduced to other more specific needs, be universal from very early in life (from infancy) and must be associated with well-being and optimal development from very early on in life (Dwek, 2017).

AN OVERVIEW OF MAJOR THEORIES ON HUMAN PSYCHOLOGICAL NEEDS

Several theories will be discussed below – this list is by no means exhaustive and only a brief chronological overview will be given (Dwek, 2017; Pittman, 2007). We will begin with Freud's theory which explored the need for interpersonal contact. This model was based on his presumption of a libidinal (sex) drive between parent and child (Freud, 1905). This has become a highly controversial subject and most practitioners and researchers do not subscribe to his model on innate libidinal drives within parent and child relationships in nuclear families. Along with his controversial theory on libidinal drive he also proposed a thanatos (aggression) drive, which serves to protect us from potential harm that may be in the way of both these drives (Freud, 1920).

Maslow (1943) in the 1940s proposed that human beings have two sets of needs. At the bottom of a proposed hierarchy and going upwards, the needs were as follows: physiological (food and clothing), safety (job security), love and belonging (friendship), self-esteem, and self-actualization. Maslow (1947) at first stated that the needs lower down in the hierarchy must be satisfied before individuals can attend to higher needs. However, he later clarified that a need would not have to be 100 percent satisfied before the next need would emerge (Maslow, 1987). Among the important perspectives emerging from Maslow's model is his view that physiological needs must first be generally satisfied before psychological ones and that both of these are essential needs for human beings.

In the 1950s, John Bowlby (1969), known as the father of attachment theory, posited that infants have a need for attachment – defined as an enduring tie with a person who provides security. Bowlby (1969) stated that a child's secure attachment would establish a base from

which to safely explore the environment and to which to return if danger or threat were perceived. The lack of establishment of a secure base was seen as disrupting an infant's development and led to many dysfunctional behaviors during the adolescent and adult stages of life (Bowlby, 1988). Children who had experienced a secure base were considered to be securely attached, and were believed to have a more developed sense of being valued, a greater sense of "felt security" and more optimistic views of social relationships (Bowlby, 1988). Conversely, when caregivers have not been consistently responsive to a child's bids for connection and expressions of autonomy, the development of defensive strategies categorized as avoidant, anxious and disorganized ensued (Bowlby, 1988). It should be noted that, while Bowlby did not link the constructs making up his attachment theory in terms of needs, it seems obvious that secure attachment is a need, since it satisfies all aforesaid criteria of a fundamental need (Dwek, 2017; Pittman, 2007).

Reality therapy (Glasser, 1965) was developed in the 1960s where the founder William Glasser where postulated five basic needs for humans, and four of them were psychological, after survival, and these were love and belonging, power and achievement, freedom or independence, and fun and enjoyment. He stated that psychological symptoms are not due to mental health condition but due to people choosing behaviors to fulfill their needs. People are guided to choose more desirable actions that would help connect them with others.

Terror management theory (Greenberg, 1997) posits that the need for self-preservation underlies all others. The need to survive is seen as the overriding aim. Since the fear of death is universal, it is assumed that the terror and anxiety associated with death influences people's thinking and behavior. This may also lead to the adoption of the values of a certain culture in order to be part of an important group and protect self-esteem. This theory does not begin at the infancy stage, but rather when a person is mature enough to conceptualize the terror of their mortality.

Another model called cognitive-experiential self-theory is based on personality theory (Epstein, 1992). This model assumes four fundamental human needs: to maximize pleasure and minimize pain; to maintain a stable, coherent conceptual system for organizing experience; to maintain relatedness to others; and to maintain self-esteem. There is no mention of this need starting at infancy. Its focus is on the four dimensional nature of information processing (Epstein, 1992).

Baumeister and Leary (1995) proposed a model on the need to belong. More specifically, this belongingness hypothesis states that humans have a need to belong to a group and that they will maintain a minimum number of lasting, significant, and positive relationships. Unlike attachment theory, the need to belong is not focused on one person, such as a primary caregiver, but rather on "significant others" early on in life.

Around this time Stevens and Fiske (1995) proposed that humans have developed five core social motives: to belong, to understand, to be effective, to find the world benevolent, and to maintain self-esteem. They see the need to belong as primary and the others as stemming from this. Little is said about what early caregivers should do to meet these needs.

Perhaps one of the most extensively researched and frequently cited models is self-determination theory. This identifies three needs believed to underpin optimal functioning and well-being: autonomy (the need to make choices freely by oneself), competence (the need to master a task) and relatedness (the need to connect with others emotionally; Ryan & Deci, 2000). These three needs are believed to be relevant across developmental periods (from childhood to adulthood), across cultures, and across personality differences (Ryan & Deci, 2017). When these needs are satisfied, they posit that intrinsic motivation (defined as when an individual chooses to engage in an activity for its own sake, whether for interest, pleasure or satisfaction), will increase. Conversely, when these needs are thwarted, intrinsic motivation will be eroded (Ryan & Deci, 2017). Studies have shown that these three psychological needs are responsible for between 15% and 50% of our well-being, psychological health, performance at work, and overall success in life (Vanden Broeck et al., 2016).

Dwek (2017) proposed a model built on the aforementioned frameworks. Her model comprises three basic needs: acceptance, predictability, and competence, and four compound needs: trust, control, self-esteem/status, and self-coherence. The need for trust comes from a combined need of acceptance and predictability; the need for control comes from competence and predictability; self-esteem from acceptance and competence. Finally, there is a need for self-coherence which itself has two sub-needs, namely, identity and meaning. This need is developed after successful integration of the other six needs. In Dwek's model, needs begin with infancy and continue into adulthood (Dwek, 2017).

Schema Therapy Model

Schema therapy is a psychotherapeutic approach developed for the treatment of personality disorders, especially for difficult-to-treat patients who did not respond to conventional methods of psychotherapy (Young et

al., 2003). When this treatment began in 1990s, the focus was on the concept of early maladaptive schemas (EMSs or "negative schemas"). EMSs are defined as having specific pattern of thoughts, emotions, beliefs, bodily sensations, and neurobiological reactions (Young et al., 2003; Lockwood & Perris, 2012; Louis et al., 2018). In schema therapy, it is theorized that EMSs develop when core emotional needs are thwarted and not adequately met by primary caregivers early on in childhood (Young et al., 2003; Louis & Louis, 2020; Louis, 2022; Louis et al., 2022). Conversely, when they are met adequately, the development of early adaptive schemas (EASs, or "positive schemas") is facilitated (Louis et al., 2018; Lockwood & Perris, 2012). Both EMSs and EASs have a solid empirical foundation. Support for EMSs has grown over the past two plus decades while support for EASs, a newer development, has grown over the past five years (Louis et al., 2018). Numerous studies over the past 25 years, with cross-cultural samples, have demonstrated the association between EMSs and ill-being (Bach et al., 2017; Lee et al., 1999; Lee et al., 2015). More recently, a total of 14 EASs have been identified using samples from the United States, Singapore, Malaysia, Philippines, and India, and all 14 EASs were found to be associated with well-being (Louis et al., 2018).

Schema therapy postulates that each EMS implies a frustrated core emotional need and, conversely, that each EAS implies a specific core emotional need that has been met adequately (Young et al., 2003). In the empirical investigations of EMSs and EASs, each corresponds to a primary factor. These primary factors have been found to consistently cluster into a secondary structure termed "schema domains" (Young et al., 2003). Since each specific EMS is believed to be associated with a specific unmet need, then each schema domain, by implication, represents a higher order of unmet need. This does not mean that each specific unmet primary need represented by an EMS is solely associated with its immediate higher order; it also correlates with other second order domains though not as strongly. While EMSs, and now EASs, are still central concepts in schema therapy, the primary focus in treatment has shifted from modifying schemas to meeting the core emotional needs from which they are believed to be derived. Effective treatment is believed to be determined by the extent to which the therapist can help his/her patient meet these needs. For example, if a patient has an unmet need for connection the therapist will serve as a transitional source of secure attachment as s/he helps the patient get needs for connection more fully met outside of the therapeutic relationship. Since an understanding of the nature of core emotional needs is so central to the process, advancing our understanding of what they are and how to best meet them seems likely to lead to improved outcomes.

Based on extensive clinical experience, Young et al., (2003) proposed a five-factor schema domain model or categories of unmet needs. These were labelled as Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, Other-Directedness, and Overvigilance and Inhibition. Many studies have assumed that this five-schema domain model had strong empirical support but that is not the case. Rather, several decades of empirical investigations of EMSs by different investigators in different parts of the world has resulted in a strong trend towards four groups of the 18 EMSs instead of five; early on being found in studies such as Hoffart et al. (2005) and continuing until more recently with Bach et al. (2018). These two were noteworthy with respect to using large clinical and non-clinical samples. When broken down into four groups rather than five, the four categories of EMSs have been labelled Disconnection and Rejection, Impaired Autonomy and Performance, Impaired Limits, and Excessive Responsibility and Standards. Louis et al., (2020), using Eastern (Singapore; Kuala Lumpur, Malaysia) as well as Western (United States) non-clinical samples, and confirmatory and multigroup confirmatory factor analysis, discovered four second order domains into which the 14 EASs clustered.

These four domains of EASs were found to parallel the four categories of unmet needs (schema domains) of the 18 EMSs. Table 1 shows the grouping of these 14 EASs into the four higher order schema domains (Louis et al., 2020). Since the development of each EAS is associated with a specific need being adequately met earlier on in life, each of the four larger domains comprising several EASs, by extension, represents a higher category of need that is believed to represent core emotional needs (Young et al., 2003; Louis et al., 2020). These core emotional needs have been labelled: Connection and Acceptance, Healthy Autonomy and Performance, Reasonable Limits, and Healthy Standards and Reciprocity. These four groups, consisting of 14 EASs, closely mirror the four larger groups of 18 EMS or schema domains (Hoffart et al., 2005; Bach et al., 2018). As theorized by Young et al., (2003), if the needs implied by these domains are not adequately met by parents or caregivers, EMSs will develop and the growth of EASs will be significantly impaired. The EMSs that develop and the EASs that do not tend to persist into adolescent and adult life often lead to significant pain and impairment in functioning. This model focuses on the early core emotional needs, which a child is largely dependent

on caregivers to fulfill and does not address needs that arise after adolescence and later developmental phases. Given their centrality to early development, they are seen as likely to be universal and less influenced by differences in culture.

Schema therapy involves the therapists helping clients meet core emotional needs (any one or more of the four core emotional needs) that have not been adequately responded to through a process called limited reparenting (Young et al., 2003). The therapist, within the bounds of the professional boundaries of a therapist-client relationship, takes on a parental role enough to create the kinds of emotional experiences that a client missed in childhood. Through this process, EMSs become weaker and EASs grow stronger, leading to the development of a stronger healthy adult. In one study by Giessen-Bloo et al., (2006) schema therapy was found to be twice as effective as transference focused psychotherapy. Limited reparenting was found to be central to its effectiveness both according the process measures used in the study and the reports of the therapists and patients' view of what were most helpful. The second aspect of the schema therapy approach that the patients found to be especially helpful was what is called the "mode model" in which the client is helped to identify four main parts of themselves: their vulnerable child, punitive parent, detached protector and health adult modes. This, among other things, helps to bring the therapist into more direct contact with the needy child part of the client. This need-affirming stance on the part of schema therapy also resulted in a significantly lower drop out rate. The patients in this study all suffered from borderline personality disorder, which is characterized by high scores on virtually all of the 18 EMSs. This is a reflection of the breadth and severity of their unmet needs. Most other approaches involve the adult therapist working with the adult patient, helping to counteract negative beliefs and irrational thoughts, phenomenon that are often symptomatic of unmet needs and expressions of a frightened, sad, or angry "inner child". The adult therapist works to help the adult patient better manage the vulnerable child part of themselves. Schema therapy, in contrast, involves the adult therapist making more direct contact with the vulnerable child in a process of helping to identify and meet core emotional needs. In the process of meeting these needs, the vulnerable child becomes more secure and loved, amongst a range of other experiences, and the adult patient's beliefs tend to become more adaptive, positive and logical; as a result, negative schemas decrease in intensity and positive schemas develop. Approaches that focus on correcting irrational thinking or training the patient to self-sooth while failing to address core emotional needs, for example, can leave the patient feeling like they are working hard to bail water out of a sinking boat that keeps springing leaks. With a systematic and comprehensive model of core emotional needs and an approach to meeting them, a secure base of growth and healing is established (i.e. the basic structure of the boat is addressed). Given the range of need taxonomies put forward by the models discussed and the central role core emotional needs have in child development, parenting and psychotherapy, it seems likely that it would be helpful to find points of convergence and to focus on ways to integrate the various constructs so as to develop a model which can draw on the strengths of each and, in so doing, be more broadly applicable and helpful. What follows is a discussion to facilitate work at this foundational level.

NEED FOR CONNECTION AND ACCEPTANCE

Connection and acceptance in the schema therapy model fits well with Bowlby's attachment theory (Bowlby, 1969; Bowlby 1988) highlighting the need for a secure base and attachment, as well as the need to maintain relatedness to others from the cognitive-experiential self-theory model (Epstein, 1992). The need for connection and acceptance also aligns with the need to belong from Baumeister and Leary's belongingness hypothesis (Baumeister & Leary, 1995) as well as the need for love and belonging from reality therapy model (Glasser, 1965) as well as to maintain relatedness to others from the five core social motives model developed by Stevens and Fiske (Stevens & Fiske, 1995). It also runs parallel with Deci and Ryan's relatedness from self-determination theory (Ryan & Deci, 2000; Ryan & Deci, 2017) and intersects with Dwek's model of acceptance, trust, and predictability (Dwek, 2017; Arntz, 2021). It even partially overlapps with the terror management theory since individuals will tend to adopt values of certain culture group and thereby feel connected to and accepted by them (Greenberg et al., 1997).

NEED FOR HEALTHY AUTONOMY AND PERFORMANCE

Healthy autonomy and performance in the schema therapy model fits well with attachment theory in that upon feeling secure with the mother, a child will develop the confidence and autonomy to explore the world and return to the secure base upon perceiving danger or threat

or when feeling the need to reconnect and "refuel". It also overlaps with the need for freedom or independence as postulated by Glasser (1965) as well as positive self-esteem in the cognitive-experiential self-theory model and with the need for positive sense of self-esteem as listed in the five core social motives model of Epstein (Epstein, 1992; Stevens & Fiske, 1995). It is similar to the need to be effective that is also part of the five core social motives model developed by Stevens and Fiske (1995). Based on the terror management theory (Greenberg, et al., 1997), self-esteem develops when a person adopts a group's value which is done to obtain protection against mortality – regardless of the motive, this is in accord with the core emotional need for healthy autonomy and performance. There was no overlap with the belongingness hypothesis developed by Baumeister and Leary (1995) but significant overlap with the autonomy construct that is part of Deci and Ryan's (2000) self-determination theory, as well as control, competence, and self-esteem in Dwek's model (Dwek, 2017; Arntz, 2021).

NEED FOR REASONABLE LIMITS

A case can be made that the need for reasonable limits from the schema therapy model converges with an aspect of the terror management theory, in that the latter induces awareness of mortality, which will motivate individuals to identify with their cultural worldview and to live up to its values, thereby motivating them to adhere to healthy limits established by the group. The stable, coherent conceptual system for organizing experience from the cognitive-experiential self-theory motivates adherence to social norms and, thus, overlaps with the notion of reasonable limits. There is also an overlap with the reality therapy model as people are guided to make the right decisions about their behavior and and have their needs met in a healthy manner There are no parallel constructs for reasonable limits in attachment theory, the belongingness hypothesis or in self-determination theory. However, the constructs of predictability, competence, and control from Dwek's model can be seen as overlapping with this construct as concurred by Arnts et al. (2021).

Table 1. The Groupings of the 14 EASs (Positive Schemas) in to Four Larger Domains Using Eastern and Western Samples (Eastern, Singapore, n = 628, Kuala Lumpur, n = 229; Western, United States, n = 214) from study by Louis et al., (2020)

Connection and Acceptance	Healthy Autonomy and Performance	Reasonable Limits	Healthy Standards and Reciprocity
• Emotional Fulfilment • Social Belonging • Emotional Openness and Spontaneity • Healthy Self-Interest / Self-Care			
	• Healthy Self-Reliance / Competence • Healthy Boundaries and Developed Self • Stable Attachment		
		• Healthy Self-Control • Success	
			• Realistic Expectations • Empathic Consideration • Self-Directedness • Self-Compassion • Basic Health /and Safety / Optimism

NEED FOR HEALTHY STANDARDS AND RECIPROCITY

There is no comparable construct of healthy standards and reciprocity with attachment theory, the belongingness hypothesis or the cognitive-experiential self-theory. According to the reality therapy model the need for power and achievement, or sense of accomplishment, as well as the need for fun and enjoyment overlaps with this need. Since the terror management theory hypothesizes that a person's thinking and behavior may change if they adopt another group's culture, this may lead to standards that contribute to well-being. And certainly the need for healthy standards and reciprocity runs parallel with competence from the self-determination theory as well as from Dwek's model delineating the need for competence, self-esteem, and control (Dwek, 2017).

DISCUSSION

What This Mean for Parents

The comparisons of these various models yielded several important points of overlap although the development of each theory was conducted from different vantage points with different psychological boundaries. Still, similar constructs of needs appeared in all the models and are summarized as follows: (1) the need for close relationships that encompasses connection on an emotional level which would include, but not be limited to, constructs such as acceptance, security, belonging, and trust; (2) the need for a sense of competence, which would promote self-esteem; (3) the need for autonomy (to explore the world based on one's own initiative and to demonstrate age-appropriate competence); (4) the need for limits and a certain measure of control to be exerted by one's social milieu; (5) the need for meaning, and for this to be integrated with a community and with the processes of the world. All constructs of needs from the various models described above overlap with at least one of these areas. Some have more broad constructs that are a combination of more nuanced ones. These psychological needs are essential and failure to have these needs met will result in psychological health being eroded over time (Young et al., 2003; Louis et al., 2018). It is also important to have all these needs met in a balanced way. Using the schema therapy model, these needs have important implications, especially for parents.

It will be helpful for parents to know what the four core emotional needs are and that by meeting them adequately, or to a "good enough" degree (Louis & Louis, 2020), they can prevent the development of active, rigid EMSs and, at the same time, foster the development of strong EASs, which continue into adolescence and adulthood. Weaker EMSs and stronger EASs were found to be linked with better psychological health and well-being (Young et al., 2003; Lockwood & Perris, 2012; Louis & Louis, 2020). Moreover, given the identification of met and unmet needs associated with the groupings of EASs and EMSs respectively, this model can also shed light on specific unmet needs, and therefore, specific EMSs and EASs, that are associated with certain personality disorders (Young et al., 2003). In other words, if a deficit of certain core emotional needs (such as connection and acceptance) consistently appear to be linked with the formation of personality disorders, then steps can be taken to rectify this. Louis et al. found that when parents spend time with their children consistently (one-on-one, and in groups), playing with them and facilitating healthy play, and when they ensure consistent family mealtimes, the need for connection and acceptance will be met to a good enough degree (Louis & Louis, 2020). Another step which fosters greater connection and prevents dysfunction is when parents process and validate their children's emotions (Gottman, 1997). When the core emotional need for reasonable limits, as well as healthy standards and reciprocity are not met, there is a greater likelihood of the child growing into an adult with narcissistic tendencies that interfere with intimacy or work or who develops a narcissistic personality disorder. Maladaptive levels of narcissism has roots in lack of limits as well as conditional love being shown by caregivers during early and late childhood and adolescents stages.

It is known that Eastern cultures are much less emotionally expressive than Western ones (Wang & Barrett, 2015). This has been viewed as just a cultural norm. However, results of the schema therapy model suggest that the well-being of children correlates with warmth. Holding and affection is part of the core emotional need for connection and acceptance, along with the freedom of expression that comes with healthy autonomy (Louis et al., 2018). Another cultural norm among Asian parents is the high expectation for academic excellence that is assumed to not be harmful and can be part of a supportive mother-child relationship (Chao, 1994). Yet the core emotional need for healthy standards and reciprocity calls for proper work-life balance and should help parents urge their children to use their natural gifts and not yield to the pressure of society, especially the pressure to excel primarily in math and science (Louis & Louis, 2020). The use of corporal punishment as a motivator by many American, Asian, and African parents (Louis

& Louis, 2020; Simons et al., 1994; Louis, 2022) is another prime example of a cultural norm that is believed to help draw out desired behavior in children. Yet many parents inadvertently abuse their children when physical punishment is administered. A study by Gershoff et al. (2010) involving mothers and children from six countries (China, India, Italy, Kenya, Philippines, and Thailand), revealed that a mother's use of corporal punishment, expressing disappointment, and yelling were significantly related to symptoms of child aggression. The core emotional need for reasonable limits calls for the use of healthy measures to discipline while maintaining connection with the child, including proper reconciliation after a disciplinary episode (Louis & Louis, 2020). Parents should also ensure that sufficient focus is given to all core emotional needs, as imbalance takes place when one is given a special emphasis to the exclusion of another. For example, when reasonable limits are introduced without sufficient connection and acceptance, the stage is set for the child to have strong EMSs such as entitlement, emotional deprivation and defectiveness, and at best weak EASs. Cultural norms or values at odds with core emotional needs may interfere with the healthy development and inadvertently inflict harm.

UNIVERSALITY OF THE SCHEMA THERAPY NEEDS MODEL AND FUTURE DIRECTIONS

One important question to address is the universality of the core emotional needs delineated by the schema therapy model. This model assumes that these needs are essential in childhood and that no new needs develops thereafter, a divergence from Dwek's model (2017) which theorizes that needs evolve and that new needs emerge and are built on other earlier ones. For example, the need for self-coherence, which itself has two subneeds, namely, identity and meaning, develops later on in life. Arntz et al. (2021) proposed a revision to the schema therapy model and put forward two more core emotional needs, namely the need for self-coherence, and the need for justice. The need for self-coherence was included since a lack of it may render the self meaningless and not integrated with the processes of the world. However, the empirical support for the addition of these two core emotional needs has yet to be demonstrated. Furthermore, this revised model was also built on Young's model (Young et al., 2003) of the five schema groupings of EMSs, a model lacking adequate empirical support unlike the model with the four groupings of EASs and EMSs which was based on multiple Eastern and Western samples (Hoffart et al., 2012; Bach et al., 2018; Louis et al., 2020). Moreover, a study by Louis et al., (Louis et al., 2022) has shown that all 14 EASs were replicated using a non-clinical samples from the USA, as well as non-clinical samples from South Africa, Nigeria, and India, bolstering support for the universality of EASs. However, further studies are needed to confirm the hypothesis that the same four higher order groupings of the 14 EASs can be found in clincal samples in Eastern and Western samples worldwide. We hypothesize that this would be the case since clinical as well as non-clinical samples have confirmed four higher order groupings of 18 EMSs by Bach et al., 2018 and Hoffart et al., (2005).

CONCLUSIONS

In closing, it is clear that the models mentioned earlier consist of constructs with significant overlap with each carrying their own definitions and having their own set of psychological boundaries. Some models do not begin with infancy; others make infancy the starting point but points of convergence of these models are clearly emerging and a foundational concept of needs can be conceptualized. Clinicians and researchers will therefore be able to test these models clinically and empirically respectively and build on the existing taxonomy of human needs and thereby contribute to better outcomes in psychological health and well-being.

Comments for reviewers: None

Ethical Considerations: Does this study include human subjects? NO

Conflict of interest: John P. Louis is a co-developer with his wife Karen McDonald Louis of a parenting program for profit and non-profit purposes. He and his wife receive revenue from the parenting program that they teach, and books that they sell worldwide. George Lockwood declare that he has no conflict of interest.

Funding sources: The authors received no funding from an external source.

Authors contributions: John P Louis: conceptualized and drafted the initial paper and used his previous published research results. Karen McDonald Louis: edited the draft. George Lockwood: edited the draft.

References

Arntz A, Rijkeboer M, Chan E, Fassbinder E, Karaosmanoğlu, A, Lee C & Panzeri M: Towards a reformulated theory underlying schema therapy: position paper of an international workgroup. Cognitive Therapy and Research 2021; 45:1007–1020.

Bach B, Lockwood G, Young JE: A new look at the schema therapy model:organization and role of early maladaptive schemas. Cognitive Behaviour Therapy 2018; 47:328-349.

Bach B, Simonsen E, Christoffersen P & Kriston L: The Young Schema Questionnaire 3 Short Form (YSQ-S3): psychometric properties and association with personality disorders in a Danish mixed sample. European Journal of Psychological Assessment 2017; 33:134-143.

Baumeister RF & Leary MR: The need to belong: desire for interpersonal attachments as a fundamental human motivation. Psychological Bulletin 1995; 117:497–529.

Bowlby J: Attachment and loss vol 1: attachment. Basic Books, New York, 1969.

Bowlby JA: Secure base: clinical applications of Attachment Theory. Routledge, London, 1988.

Cambridge University Press. (n.d.). Available online: https://dictionary.cambridge.org/us/dictionary/english/want (accessed on 15 April, 2023).

Chao R: Beyond parental control and authoritarian parenting style: understanding Chinese parenting through the cultural notion of training. Child Development 1994; 65:1111–1119.

Deci EL, & Ryan RM: The "what" and "why" of goal pursuits: human needs and the self-determination of behavior. Psychological Inquiry 2000; 11:227-268.

Dweck CS: From needs to goals and representations: foundations for a unified theory of motivation, personality and development. Psychological Review 2017; 124:689–719.

Deckers L: Motivation: biological, psychological, and enviromental. Routledge, New York, 2018.

Hoffart A, Sexton H, Hedley LM, Wang CE, Holthe H, Haugum J A et al.: The structure of maladaptive schemas: a confirmatory factor analysis and a psychometric evaluation of factor-derived scales. Cognitive Therapy and Research 2005; 29:627-644.

Epstein S: Coping ability, negative self-evaluation, and overgeneralization: experiment and theory. Journal of Personality and Social Psychology 1992; 62:826-836.

Freud S: Three essays on the theory of sexuality. In Strachey J. (eds): The standard edition of the complete psychological works of Sigmund Freud; 7:125–245. The Hogarth Press, London, UK, 1905.

Freud S & Jones, E. (Ed.). Beyond the pleasure principle.The Hogarth Press, London, UK, 1920.

Giesen-Bloo J, van Dyck R, Spinhoven P, van Tilburg W, Dirksen C, van Asselt T et al.: Out-patient psychotherapy for borderline personality disorder: randomized trial of schema-focused therapy vs. transference focused psychotherapy. Archives of General Psychiatry, 2006; 63:649–658.

Gershoff ET, Grogan-Kaylor A, Lansford JE, Chang L, Zelli A, Deater-Deckard K et al.: Parent discipline practices in an international sample: associations with child behaviors and moderation by perceived normativeness. Child Development 2010; 81:487-502.

Gottman JM, DeClaire J: Raising an emotionally intelligent child. Simon & Schuster, New York, 1997.

Glasser W: Reality therapy: a new approach to psychiatry. Harper & Row, New York, 1965.

Greenberg J, Solomon S & Pyszczynski T: Terror management theory of self-esteem and cultural worldviews: empirical assessments and conceptual refinements. In Zanna MP (ed): Advances in Experimental Social Psychology, 61–139. Academic Press, 1997.

Lee SJ, Choi YH, Rim HD, Won SH & Lee DW: Reliability and validity of the Korean Young Schema Questionnaire-Short Form-3 in medical students. Psychiatry Investig., 2015; 12:295–304.

Lee CW, Taylor G, & Dunn J: Factor structure of the schema questionnaire in a large clinical sample. Cognitive Therapy and Research 1999; 23:441-451.

Lockwood G, & Perris P: A new look at core emotional needs. In Broersen J &vanVreeswijk M (eds.). The Wiley-Blackwell handbook of schema therapy, 41–66. Wiley, Chichester, UK, 2012.

Louis JP, Louis KM, & Young AM: Positive schemas: replication, associations with negative schemas, and the Dark Triad. Psychological Reports 2022.

Louis JP: The Young Parenting Inventory (YPI-R3), and the Baumrind, Maccoby and

Martin parenting model: finding common ground. Children 2022; 9:159.

Louis JP, Davidson A, Lockwood G, & Wood A: Positive perceptions of parenting and their links to theorized core emotional needs. Journal of Child and Family Studies 2020; 29:3342–3356.

Louis JP, Louis KM: Good enough parenting: an in-depth perspective on meeting core emotional needs and avoiding exasperation (2nd ed.). Louis Counselling & Training Services Pte. Ltd., Singapore, 2020.

Louis, JP, Louis KM., & Lockwood G: Development and validation of the Young Parenting Inventory (YPI-R3) for measuring past deviant and normal variations in parenting. Children (Basel, Switzerland), 2022; 9:706.

Louis JP, Wood A, & Lockwood G: Development and validation of the Positive Parenting Schema Inventory (PPSI) to complement the Young Parenting Inventory (YPI) for schema therapy (ST). Assessment 2018.

Louis JP, Wood A, Lockwood G, Ho MHR & Ferguson E: Positive Clinical Psychology and schema therapy: the development of the Young Positive Schema Questionnaire (YPSQ) to complement the Young Schema Questionnaire (YSQ-S3). Psychological Assessment, 2018; 30:1199–1213.

Maslow AH: A theory of human motivation. Psychological Review 1943; 50:370-96.

Maslow AH: Motivation and personality (3rd ed.). Pearson Education, New Delhi, India, 1987.

Pittman TS, Zeigler KR: Basic human needs. In Kruglanski AW & Higgins ET (eds): Social psychology: handbook of basic principles, 473–489. The Guilford Press, New York, 2007.

Ryan RM, Deci EL: Self-Determination Theory and the facilitation of intrinsic motivation, social development, and well-being. American Psychologist 2000; 55:68-78.

Ryan RM, Deci EL: Self-Determination Theory: basic psychological needs in motivation, development, and wellness. Guilford Publishing, New York, USA, 2017.

Seligman MEP: Authentic happiness: using the new positive psychology to realize your potential for lasting fulfilment. Free Press, New York, 2002.

Stevens LE & Fiske ST: Motivation and cognition in social life: A social survival perspective. Social Cognition 1995; 13:189–214.

Van den Broeck A, Ferris DL, Chang CH, Rosen CC: A review of Self Determination Theory's basic psychological needs at work. Journal of Management 2016; 42:1195-1229.

Simons RL, Johnson C, Conger RD: Harsh corporal punishment versus quality of parental involvement as an explanation of adolescent maladjustment. Journal of Marriage Family 1994; 56:591–607.

Wang J, Barrett KC: Differences between American and Chinese preschoolers in emotional responses to resistance to temptation and mishap contexts. Motiv Emot., 2015; 39:420–433.

Wood A & Johnson J (eds): The Wiley handbook of Positive Clinical Psychology. Wiley, Chichester, UK, 2016.

Young JE, Klosko JS, & Weishaar ME: Schema therapy: a practitioner's guide: The Guilford Press, New York, 2003.

Correspondence:
John Philip Louis
UCSI University, Department of Psychology
Kuala Lumpur 56000, Malaysia
johnphiliplouis@gmail.com