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The needs structure of outpatients with paranoid schizophrenia

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The needs structure of paranoid schizophrenic outpatients was estimated by using valid and reliable psychological diagnostic techniques. The aim of this work has been an attempt to describe the needs structure in paranoid schizophrenia and to compare it with the healthy controls. 70 outpatients (35 males and 35 females) aged 38-46 and 70 matched controls have been examined using the Polish adaptations of „Adjective Check List" and „Stern Activities Index". It was found out that the greatest differences and intensity took place for harmavoidance, blamavoidance, infavoidance (safeness), need for succorance, order, deference and abasement; the lowest level was found out for need for changes, aggressiveness, exhibition and dominance.

Key words: paranoid schizophrenia, needs structure.

Introduction

There are changes occurring in the personality of a paranoid schizophrenic individual [5], the structure of which bears both pathological and adaptable features [37]. Therefore, it appears significant to pose the question how much potential our patients realise.

Maslow assumes [21, 22] that fulfilling our needs, the higher ones in particular, is conducive to mental health and furthermore diminishes the risk of pathology, whereas owing to unfulfilled needs, especially the basic ones, an individual develops psychopathology. The author recognises a mental disease as a typical result of unmet psychological needs. Healthy people are able to fulfil them, while the unhealthy ones are not. That is to say, Maslow believes that unmet needs play an important role in psychopathogenesis; similar inference can be found in some other research works [16, 18, 19, 27, 46, 52].

The studies of the schizophrenic outpatients' needs structure are not numerous; the motivation aspect has been of more interest with regard to the study of the cognitive functioning of paranoid schizophrenic patients.

Many people suffering from paranoid schizophrenia chronically show low motivation (under-motivation) – Buss [4] maintains that out of various impulses different to

the case of healthy people only physiologically important punishment such as electric shock or a sudden noise offers a more striking result. Thompson and Glad [45] have established the following order of needs importance with regard to patients with non-paranoid schizophrenia – the needs (n.) for aggression, abasement, affiliation, help and homosexuality. Passiveness and dependence seem to be basic features of their needs structure. Vieldman [47] has noticed that the need for achievement is smaller among unemployed patients than among the employees. Wilson [50] claims that individuals with schizophrenia as compared to healthy people reveal more motivation to avoid failure than to achieve success. As regards the intensity of the need for dependence, Scagnelli [33] has detected significant differences between paranoid and non-paranoid schizophrenic patients. Birchwood and Smith [2] declare an individual with schizophrenia to have the following needs – the need for return to the social functioning and fulfilling roles, n. for prevention of recurrence of the disease, n. for the contraction of distress caused by persevering symptoms, and n. for improvement in family relations.

In Poland Anna Suchańska [42, 43, 44] claims that for patients with paranoid schizophrenia whose functioning in society is constructional important needs are a n. for protection and n. for aggression. Patients who show de-constructional adaptation, by contrast, they lack affiliation needs and the needs structure is of passive and dependent character. Aggression tendencies and the following needs are typical of the system – a n. for help, submission, and an inferiority feeling.

In the study of the quality of life and the needs of paranoid schizophrenic patients it is taken into consideration that the relations between their objective and subjective evaluation are complex [13, 32]; as a consequence, the issue of the patient's subjective experiencing of the disease is growing considerably important.

Objective

The aim of this work is to:

1. Describe the paranoid schizophrenic outpatients needs structure profile,
2. Find out the differences of their needs structure as compared to healthy controls.

Material and method

In the Mental Health Outpatient Clinic in Wielun 70 outpatients with paranoid schizophrenia were examined. The patients have been accepted on the following basis:

a) Psychiatric diagnosis of paranoid schizophrenia (ICD-9 and DSM III-R criteria), as a result of which the patient has been hospitalised several times
b) Psychological diagnosis both clinical and psychometrical, based on the Polish version of MMPI by Paluchowski and Jakubowski (appendix I) [23, 25, 28, 35].

In the group of the examined patients there were 35 women and 35 men. They were all treated with traditional neuroleptics; the clinical picture came out to be typical of

paranoid type of schizophrenia. The patients' ages ranged from 34 to 46 (mean 40.5). They were qualified for the psychological examination in reference to their needs structure as soon as psychiatric and psychological diagnoses entered an agreement; the patients were in the phase of remission of positive symptoms, which allowed psychological examination. A healthy control group was chosen in a three-stage selection, that is layer, group, individual, out of whose age, sex, social and economical status criteria were matched; in addition, they could not be registered in a Mental Health Clinic.

In order to examine the needs structure, the Polish version of the "Adjective Check List" (ACL) by Gough and Heilbrune jr. and adapted by Matkowski (appendix II) [8, 9, 23, 51], which can also be applied in self-acceptance and sense of optimism estimation (Matkowski's scales), was put in use; in addition to this, the Polish version of "Stern Activities Index" (SAI) by Stern was also used (appendix III) [29, 40, 41]. Both tests were employed on the grounds of the ease with which they can be carried out; they also analyse needs structure in Murray's conception [26] which is considered to be the most detailed and developed conception of needs.

The data obtained has been submitted to statistical analysis with the help of "Statistica PL" [39].

Results

The result of the study of the needs structure and personality traits of paranoid schizophrenic outpatients as well as of healthy individuals reached in ACL can be found in Table 1 and Chart 1.

Out of 40 applied ACL scales the groups differed in twenty-five. Comprehensive confrontation of personality profiles in ACL reveal that the mean scores as for paranoid schizophrenic outpatients is often lower than with healthy persons; it proves that the first group display a lesser ability to adapt in both personal and interpersonal terms.

In "modus operandi scales", which to some extent function as control scales, paranoid schizophrenic outpatient attained statistically a much lower level in the scales of NCk (Number of Adjective Checked), Com (Communality), and Dfn (Defensiveness).

The results achieved in the need scales show the personality specificity of paranoid schizophrenic outpatients. Out of 15 need scales, paranoid schizophrenic outpatients attained a lower level in the scale of the need for achievement (Ach), dominance (Dom), affiliation (Aff), heterosexuality (Het), exhibition (Exh), autonomy (Aut), and change (Cha); they attained significant higher level in the scale of the need for succorance (Suc), abasement (Aba), and deference (Def).

As regards the topic scales, which evaluate each aspect of interpersonal behaviour, statistically significant differences were detected in six traits of personality. Outpatients with paranoid schizophrenia achieved higher level in the counselling readiness scale (CRS) and furthermore in the scale of self-control (S-Cn); the level was lower in the scale of self-confidence (S-Cf), ideal self scale (ISS), creative personality scale (CPS), and masculine attributes scale (Mas). Out of the scales based on the transaction analysis theory, statistically significant differences were found in the "adult" ego state scale (A);

Table 1

The comparison of mean scores (± SD) of ACL scales showing the needs structure of paranoid schizophrenic outpatients and healthy controls

ACL SCALES	CONTROLS		PARANOID SCHI		SIGNIFICANCE LEVEL	
	MEAN	SD	MEAN	SD	t	p
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Table continued on the next page

30. CP	4.90	4.43	4.42	4.87	0.58	NS.
31. NP	6.08	5.44	4.82	5.95	1.03	NS.
32. A	1.16	4.94	2.96	4.73	-1.68	0.04
33. FC	-1.34	4.40	-3.72	3.74	2.77	0.003
34. AC	-2.60	6.46	-2.08	5.18	-0.45	NS.
35. A1	4.04	3.14	3.18	3.21	1.36	NS.
36. A2	5.66	3.62	3.94	3.76	2.35	0.01
37. A3	7.10	4.17	5.40	3.38	2.28	0.01
38. A4	4.00	2.46	2.76	3.16	2.31	0.01
39. S-Ac	10.72	5.90	8.82	7.54	1.51	NS.
40. Opt	8.90	5.55	2.80	5.53	5.54	0.0000

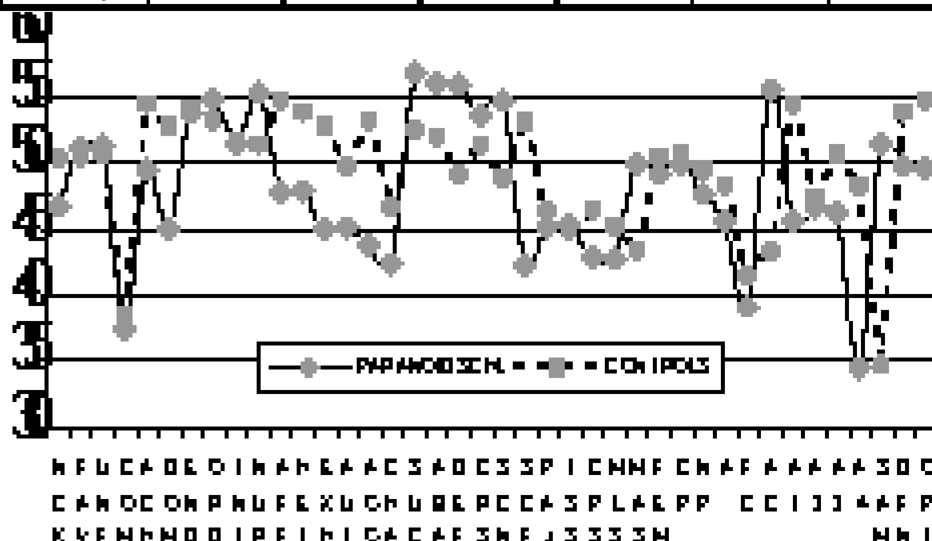

Chart 1 Mean scores of ACL scales showing the needs structure of paranoid schizophrenic outpatients and healthy controls

the paranoid schizophrenic outpatients attained a higher level than the healthy controls.

A2, A3, and A4; the paranoid schizophrenic outpatients attained a lower level.

In Matkowski scales in the optimism scale (Opt) the paranoid schizophrenic outpatients attained a significantly lower level.

The results of the study of the needs structure and personality traits of paranoid schizophrenic outpatients as well as of healthy persons reached now in SAI can be found in Table 2 and Chart 2.

Out of thirty applied SAI scales the groups differed in twenty two. Comprehensive comparison of personality profiles in SAI reveals the patients to have a lesser abil-

Table 2

The comparison of mean scores (± SD) of SAI scales showing the needs structure of paranoid schizophrenic outpatients and healthy controls

SAI SCALES	CONTROLS		[illegible]		SIGNIFICANCE LEVEL	
	MEAN	SD	MEAN	SD	t	p
1. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
2. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
3. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
4. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
5. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
6. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
7. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
8. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
9. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
10. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
11. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
12. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
13. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
14. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
15. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
16. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
17. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
18. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
19. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
20. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.
21. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
22. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
23. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
24. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
25. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
26. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
27. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
28. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
29. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
30. [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	N.S.

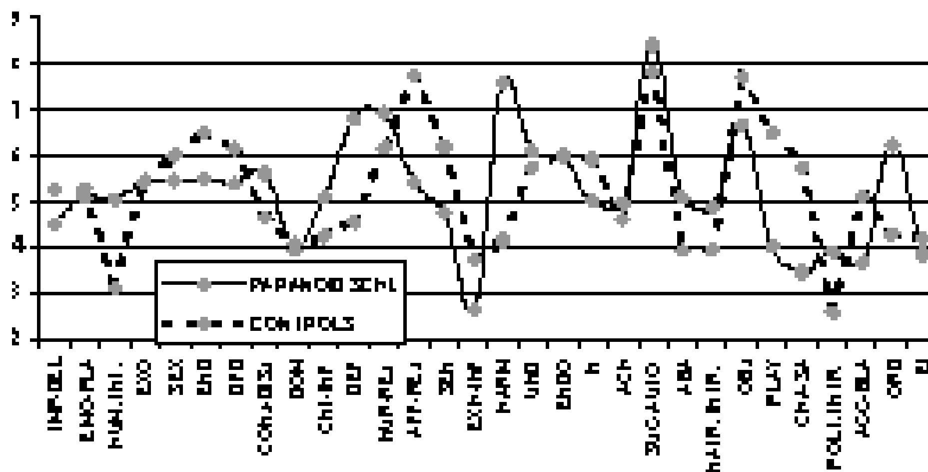

Chart 2 **Mean scores of SAI scales showing the needs structure of paranoid schizophrenic outpatients and healthy controls**

counteraction, the opposite pole of which is the need for infavoidance (Cnt-Inf), deference (Def), nurturance with the opposite pole-the need for rejection and seclusion (Nur-Rej, Sec), affiliation with the opposite pole-rejection and isolation (Aff-Rej, Sec), sentience (Sen), exhibition with the opposite pole-infavoidance (Exh-Inf), harmavoidance (Harm), succorance with the opposite pole-autonomy (Suc-Aut), abasement (Aba), play (Play), aggression with the opposite pole-blamavoidance (Agg-Bla), and the need for order (Ord).

Out of scales, which examine general personality traits statistically significant differences were found in the scale Cha-Sa (Change-Sameness), Conj-Disj (Conjuctivity-Disjunctivity), End, Int (Endurance, Intensity), Imp-Del (Impulsion-Deliberation), Obj-Proj (Objectivity-Projectivity).

Out of various inner factors statistically significant differences were found in the scale of narcism (N), and moreover in the scales, which examine humanistic, natural science and social and political interests.

Discussion

Murray [26] systematised the needs of the individual; in this conception the needs and personality structure among paranoid schizophrenic outpatients can be examined in specific groups of needs, which inter-act and create certain configurations that are presented below.

I) n Dominance (Dom)n Autonomy (Aut) n Aggression

(Agg)
n Deference (Def) nAbasement (Aba)

At the top of the above configuration there are variables of the intensity of activity, expansion, domination, supremacy, independence or even aggression. In the scales of both ACL and SAI paranoid schizophrenic patients attained a lower level than the healthy controls. At the bottom the variables refer to the inferiority feeling, submission, abasement, passiveness, withdrawal; the results achieved shows a greater intensity of such traits among paranoid schizophrenic outpatients than the healthy controls.

II) n Achievement (Ach) Ego Ideal.

The ego ideal is a group of imagined aims within the need for achievement, in other words, it is a picture of an ideally successful self. The ego ideal is the manifestation of the latent or unrealised need for achievement (ln Ach); both variables are of a considerably less intensity among paranoid schizophrenic patients than the healthy conrols. Similaerly, Vielman [47] points to little motivation for achievement. Other authors [34, 48] focus on "the sense of self", ego pathology, and self experience in schizophrenia as well.

III) n Sex (Sex) n Exhibition (Exh)
n Sentience (Sen) n Play (Play).

In the above group the needs are for contentment gained through, e.g. erotic experience, arousal, sensual pleasure, humour, imagination, and play; a significant less intensity is noticeable among paranoid schizophrenic outpatients, which may hint in anhedonia [1, 20]. Weak tendency to draw other's attention to oneself may result from wanting to "hide" and not to expose oneself to danger-"I'd rather stay home than go out and possibly get hurt"; anticipation of unfavourable and unpleasant events is typical of pessimistic attitude which may lead to depression [36].

IV) n Affiliation (Aff) n Rejection, Seclusion (Rej, Sec)
Narcism (N).

Need for affiliation designates positive tropism towards people, while need for rejection and seclusion negative; the both needs usually exist simultaneously in accordance with object or its classes. Paranoid schizophrenic outpatients' need for affiliation is significantly lower, which results in narcism intensity being smaller as need for affili-

ation directed inwards (intra Aff). Other authors, as well, focus on patients' difficulty in interpersonal relations and in social functioning; they perceive social withdrawal as one of the factors of symptomatology of paranoid schizophrenia found in factor analysis [6, 10, 12].

V) n Succorance (Suc) nNurturance (Nur).

The above mentioned needs offer help and succorance, that is receiving and giving help and support. The intensity of both needs is much greater among paranoid schizophrenic outpatients, even though their affiliation tendencies are much weaker.

VI) n Blamavoidance (Bla).

The need, like other components of need for safeness (Harm, Inf), is of greater intensity among paranoid schizophrenic outpatients.

VII) n Infavoidance (Inf) n Defendance (Dfn)
nCounteraction (Cnt)

This group comprises of types of behaviour, which define the individual's want to oppose his/her status being lowered. The above mentioned needs are various aspects of need for inviolacy (Inv) that denotes the patients' tendencies to maintain their status or to avoid criticism either from others or the patients themselves. Among the paranoid schizophrenic outpatients the intensity of the needs is significantly greater, except for need for defendance.

Need for infavoidance (Inf) and blamavoidance (Bla) derive from the need for harmavoidance (Harm); the three components of need for safeness provide a basis for a variable of "anxiety". Among the paranoid schizophrenic outpatients intensity of need for safeness is significantly greater.

VIII) n Order (Ord) Impulsion-Deliberation (Imp-Del)
Conjunctivity-Disjunctivity (Conj-Disj) Emotionality-Placidity (Emo-Pla)
Change-Sameness (Cha-Sa)

The variables that compose the group refer to the level of organisation, stability, and rigidity of personality; their intensity is significantly greater among the paranoid schizophrenic outpatients, which is caused by greater intensity of the need for safeness. One can say that "order" is of compensation character-putting the world around oneself in order counteracts catastrophic reaction; it is characteristic of self-preservation

level [44].

IX) Intensity (Int) Endurance (End)

Murray treats both variables as means of measurement of élan vitality (vigour) emission; the life energy (vigour) is significantly weaker among paranoid schizophrenic outpatients as compared to healthy controls.

The above evaluation shows that paranoid schizophrenic outpatients lack the "spark and joy of life". They do not manifest "acute" (so called productive, positive) psychotic symptoms, but lack of initiative, retreat from people and every-day situations (withdrawal?), general inhibition and restrain and excessive self-control hint in so called negative symptoms. The symptoms imply process, chronic or type II schizophrenia: apathy, social withdrawal, social malfunctioning, weak affect, motivation and life activity decrease. The symptoms may as well signal schizophrenia deficit or residual schizophrenia [3, 11, 31, 49].

Yet still the "deficit" picture is flawed by tendencies "toward people" and minute or weak tendencies "against people". The patients show need for receiving help and succorance as well as need for nurturing, helping, and supporting others; other authors mention need of succorance [17]. One may assume that paranoid schizophrenic outpatients do not build interpersonal relations on their affiliation need but rather on the "exchange" of love, affection, support and help ("giving" and "taking"): the "exchange" phenomenon has received attention in other studies as well [15].

Various authors have written about a passive and dependent character of the personality structure among paranoid schizophrenic outpatients [7]; what is more, some of them claim dependence needs to be the fundamental element of paranoid symptomatology [33]. The results of this study to some degree verify observations made by other researchers. Low levels for needs that activate and actuate behaviour and the lack of spontaneity and emotional inhibition were found. The interpretation of these results seems to be worth discussing; probably we do not deal with "passive motivation" but with "low life dynamics" (weak life force) which leads to low motivation in general, to achievement and success particularly. Strong tendencies to offer help and support to people in need which cannot possibly be qualified for the pattern of "dependence-passiveness" structure act in favour of this statement.

There were quite different results in the case of aggressive and exhibitionistic tendencies: according to some authors they are rather strong [7, 44, 45]; yet in this study they were of slight intensity. Similarly divergent results were found in the case of egocentric character of the motivation structure: contrary to some studies, there were no such traits found in the patients examined and what is more they showed allocentric traits and tendencies.

If we accept Maslow's idea that needs for safeness (together with physiological needs and connected values) are basic in the needs hierarchy, it easy to understand

that the patients' activity is directed mainly and first of all to the fulfilling of safeness needs. It happens because unmet "lower" needs begin to dominate and win when there is a conflict with unmet "higher" needs.

The above given assumptions were adopted in the program of rehabilitation, the fundamental elements of which were fulfilling the physiological and safeness needs, restitution of affiliation and recognition needs, and forming the self-realisation need in chronic patients [38]. Need-adapted treatment [30] and "personal therapy" [14] representatives stress the importance of including needs in the treatment of schizophrenia.

Conclusions

1. The needs structure of paranoid schizophrenic outpatients (in the remission of positive symptoms phase) undergoes changes.
2. The needs structure of paranoid schizophrenic outpatients after comparing with the healthy controls differs, mostly in the following: more intensive are the needs for safeness, order, "exchange" of help and succorance, deference and abasement; less intensive are being felt the "hedonistic" needs and needs for aggression, domination and achievements.
3. The values hierarchy of outpatients with p.s. after comparing with the normals differs, mostly in the following: the allocentric, social, interpersonal and moral values are of high positions but the egocentric, personal, competence and individual values are of low positions.
4. The self-realisation process of paranoid schizophrenic outpatients has been inhibited, because some needs of fundamental importance for the personality development of paranoid schizophrenic outpatients are not fulfilled (gratified).

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APPENDIX I

The MMPI qualification criteria: a) absence of types of malingering or aggravation in the personality profile (control scales configuration and Gough's index): $-8\ ^{3}\ F\text{-}K \leq 14$); b) clinical scales configuration in the personality profile, especially 6 (pa) and 8 (Sc); c) Goldberg's indices; d) Petersen's criteria and Taulbee-Sisson index.

APPENDIX II – ACL

A. MODUS OPERANDI SCALES: 1) No.Ckd-Number of Adjectives Checked; 2) Fav-Number of favorable adjectives; 3) Unfav-Number of unfavourable adjectives; 4) Com-Comunality; 5) Dfn-Defensivness (from the previous version of the technique)

B. NEED SCALES: 6) Ach-Achievement; 7) Dom-Dominance; 8) End-Endurance; 9) Ord-Order; 10) Int-Intraception; 11) Nur-Nurturance; 12) Aff-Affiliation; 13) Het-Heterosexuality; 14) Exh-Exhibition; 15) Aut-Autonomy; 16) Agg-Aggression; 17) Cha-Change; 18) Suc-Succorance; 19) Aba-Abasement; 20) Def-Deference
C. TOPIC SCALES: 21) CRS-Counceling Readiness Scale; 22) S-Cn-Self-Control; 23) S-Cfd-Self-Confidence; 24) P-Adj- Personal Adjustment; 25) ISS-Ideal Self Scale; 26) CPS-Creative Personality Scale; 27) MLS-Military Leadership Scale; 28) Mas-Masculine Attributes Scale; 29) Fem-Feminine Attribute Scale
D. TRANSACTIONAL ANALYSIS SCALES: 30) CP-Critical Parent; 31) NP-Nurturing Parent; 32) A-Adult; 33) FC-Free Child; 34) AC-Adapted Child
E. WELSH (Origence-Intellectence) SCALES: 35) A1-High Origence-Low Intellectence; 36) A2-High Origence-High Intellectence; 37) A3-Low Origence-Low Intellectence; 38) A4-Low Origence-High Intellectence
F. MATKOWSKI SCALES: 39) S-ac-Self-Acceptance; 40) Opt-Optimism.

APPENDIX III - SAI

1) Impulsion/Deliberation (Imp/Del); 2) Emotionality-Placidity (Emo-Pla); 3) Humanistic interests; 4) Exocathection (Exo); 5) n Sex (Sex); 6) Endurance, Intensity (End,Int); 7) n Defendance (Dfn); 8) Conjunctivity/Disjunctivity (Conj/Disj); 9) n Dominance (Dom); 10) n Counteraction-n Infavoidance (Cnt-Inf); 11) n Deference (Def); 12) n Nurturance-n

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