The utility of modified version of sentence completion test for children and adolescents

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ABSTRACT

Introduction: Sentence completion test (SCT) is a projective test used widely by clinicians and psychologists to explore the needs, inner conflicts, fantasies, attitudes, aspirations, adjustment difficulties, and sexual abuse in the children and adolescents. Aim: The aim of the study is to modify the existing SCT (Form S) for children and adolescents and to corroborate with clinical history. Methodology: A pilot testing was done on 35 children and adolescents who were referred to the Department of Clinical Psychology section for evaluation of conflicts after a detailed evaluation by psychiatrist(s). The clients were administered both the unmodified and the modified SCT. The information obtained was compared between (i) unmodified and the modified SCT and (ii) between clinical history and modified SCT. The psychologist was blind to the assessment of the patient done at the time of workup by a psychiatrist. The two information were analyzed. Descriptive analysis was carried out. Results: The modified version of SCT gave more comprehensive information on all areas of the patient’s life compared to older version. The information obtained corroborated with the clinical history explored by the psychiatrist. This test can be administered with ease and can yield detailed information in a wide range of stress-related and neurotic disorders, which can be utilized for clinical case management. Conclusion: The modified SCT may better complement clinical history in eliciting comprehensive information on psychosocial issues and better formulation of management plan.

Keywords: Adolescents, children, conflicts, modified sentence completion test, psychiatric illness, sentence completion test

The sentence completion test (SCT) is a semistructured projective technique for clinical psychologists and professionals dealing with child and adolescent problems, who need to explore the needs, inner conflicts, fantasies, sentiments, attitudes, aspirations’ and adjustment difficulties of their clients. Such information is helpful in screening children and adolescents for therapy and offers the therapist significant clues to the content and dynamics of children’s inner feelings.

Direct questioning tends to make the individual self-conscious and likely to put him/her on the defensive. However, while administering SCT, when an individual is advised to respond with the first idea that occurs to him/her, he/she usually offers significant material that he/she does not censor. When faced with the situation of structuring an unstructured situation, an individual’s response will be indicative of the true nature of his/her own reactions and sentiments; and in talking about a third person, an individual is apt to reveal himself/herself. Moreover, when the sentence does not exist or there’s only one sentence, the possibility that the child or adolescent may forth come with that particular information becomes almost nil.

Use of SCT is favored because it is easy to administer, yields important information regarding various areas of an individual’s life, and may be superior to other measures in...
uncovering a person's conflicts because of its ambiguous nature. Therefore, it has important consideration in many clinical situations, particularly emotional problems.

At present, the Indian adaptation of the Rotter's Scale by Verma et al., 1985[1] with the name “PGI Sentence Completion Test” is in clinical practice. It was made in Hindi and has three standardized forms – Form G (for general use) with 35 items, Form M (for married people) with 25 items, and Form S (for students) with 20 items.

Based on our experience of administering this test, we have encountered the difficulties in the content of majority of the statements. Majority (55%) of the statements were related to academic difficulties such as education, grade, and studies in general. Only a few items addressed the family area, interpersonal relationships, goals, and self-concept. Hence, there was a dire need to revise the present scale, to include other areas of interest that are of importance to a child and the social milieu, particularly in today's changing structure and function of the family and society.

Although Hermann Von Ebbringhaus is credited with developing the first SCT in 1987, a series of SCT have been developed over the years.[2-11] Recently, a retrospective study[2] analyzed 27 Indian children and adolescents below 16 years of age, diagnosed with emotional disorders. Here, SCT (Form S and Form G) was used as one of the tools to assess conflicts. The areas of conflicts that emerged on SCT were conflict with parents, with family, toward heterosexual relationships, with seniors, with teachers, with parents, with women, and toward self. Form S gave very restricted information and Form G had to be administered for additional information. This study possibly indicates that all these areas need to be added to have an in-depth understanding of children and adolescents, to manage their emotions and behavior adequately, and to facilitate their better learning and adjustment to the environment. The current study of modifying PGI SCT aims to evaluate the major areas of family, heterosexual relationships, interpersonal relationships, and self-concept.

**Aim**

The aim of the study is to modify the existing SCT (Form S)[1] for children and adolescents and to corroborate with clinical history.

**METHODOLOGY**

Thirty-five children and adolescents, both males and females in the age range of 8–19 years who were referred (after the case is worked up and discussed in detail with the consultant psychiatrist) to the Division of Clinical Psychology, Department of Psychiatry of our institute, for assessment of conflicts were included in the study. A pilot testing was done on these individuals. The clients were administered both the unmodified and the modified SCT. The information obtained was compared between (i) unmodified and the modified SCT [Table 1] and (ii) between clinical history and modified SCT. After completing the test, each response was discussed in detail with the patient, and the information was gathered and documented in detail. An independent psychiatrist evaluated and recorded the clinical history during the detailed workup. The psychologist was blind to the detailed examination and findings by the psychiatrist. The two information were then corroborated and recorded.

The modification of the tool was based on the author's clinical experience and changing structure and function of society and family. The unmodified version is highly loaded with scholastic and academic items and yields restricted information, and we incorporated the domains from the Sacks SCT. Questions were framed in Hindi language addressing family, sexual adjustment, interpersonal relationships, and self-concept. Questions relevant to school and academics were retained from previous SCT. The revised version of SCT Form S (Student form) was derived from Sacks SCT[9] and PGI SCT.[1] The family area included three sets of attitudes as follows: those toward mother, father, and family unit. The sexual adjustment area included attitudes toward women and toward heterosexual relationships. The area of interpersonal relationships included attitudes toward friends and acquaintances, colleagues at work or school, and superiors at work or school. Self-concept involved fears, guilt feelings, goals and attitudes toward one's own abilities, past, and future. Finally, the modified test consisted of thirty items, of which each area was represented by two items.

Descriptive analysis was carried out using percentages for discontinuous clinical variables. Statistical comparisons were carried out using Chi-square test between variables in the modified SCT and clinical history. However, such statistical comparisons could not be done between the unmodified and the modified SCT as the information in unmodified SCT was skewed toward school and academics.

**RESULTS**

As shown in Table 2, the mean age of the patients was 12.5 years. The age range of the patients was 8–19 years. Majority of patients were males (57%). The ICD 10 diagnosis in patients belonged to the categories of neurotic and stress-related disorders, depressive disorders, and behavioral and emotional disorders with onset in childhood.
On the unmodified SCT, there was no scope of unraveling the conflicts related to home, relationships, fear, etc., and was not spontaneously mentioned by subjects as opposed to the new one. The modified SCT revealed fear and guilt in majority of the patients [Table 1]. A comparison could not be drawn because the information elicited was totally skewed toward studies and school in modified version. This was followed by conflicts in areas of attitude toward family unit and attitude toward mother, father, heterosexual relationships, friends, superiors, own abilities, future, goals, and women. In some, it provided more detailed information as compared to the first clinical history documented in case files. This is of advantage as sometimes during clinical interview children and adolescents might not give complete information. It might take few sessions to develop rapport and get to the details of the stressors and psychosocial issues.

There are several factors that contribute to child’s well-being and development, in the absence of which there is emergence of psychopathology. Family relationships have the most significant impact on children. External factors, such as life events, sudden changes in circumstances, and family relationships, hamper the conditions to learn, develop, and prosper. Cognitive and emotional development, through access to play in the early years at school, is a key area of child’s life where experiences vary greatly and negative experiences have a significant impact on his/her well-being. Majority of children enjoy school activities and feel that it is a great learning experience. However, there are some who remain unhappy about their relationships with teachers and friends. Some teachers feel their children are more likely to have low levels of happiness at school. Children need to see themselves in a positive light, and deserve to feel, and be respected by all adults and other children. Feelings and perceptions about self are strongly associated with self-concept. Children who feel their views are taken seriously and are treated fairly in key areas of their lives have a more positive view of them, resulting in greater well-being.

In the recent decades, there has been an apparent change in the Indian society owing to industrialization, urbanization, increase in education, legislative measures, and social

**DISCUSSION**

The modification of the existing SCT aimed to include various aspects having influence on child development, psychopathology, and symptoms. In the modified SCT, there emerged conflicts in themes of fear in all the patients, followed by feelings of guilt; conflicts in areas of attitude toward family unit; and attitude toward mother, father, heterosexual relationships, friends, superiors, own abilities, future, goals, and women. In some, it provided more detailed information as compared to the first clinical history documented in case files. This is of advantage as sometimes during clinical interview children and adolescents might not give complete information. It might take few sessions to develop rapport and get to the details of the stressors and psychosocial issues.

**Table 1: Conflicts elicited on modified sentence completion test and unmodified sentence completion test (n=35)**

| Domains                                    | Conflicts present on modified SCT, n (%) | Conflicts present on unmodified SCT, n (%) |
|--------------------------------------------|----------------------------------------|-----------------------------------------|
| Attitude toward mother                     | 25 (71)                                | -                                       |
| Attitude toward father                     | 24 (69)                                | -                                       |
| Attitude toward family unit                | 26 (74)                                | -                                       |
| Attitude toward women                      | 6 (17)                                 | -                                       |
| Attitude toward heterosexual relationships | 20 (57)                                | 7 (20)                                  |
| Attitude toward friends                    | 18 (51)                                | -                                       |
| Attitude toward superiors                  | 18 (51)                                | -                                       |
| Fears                                      | 35 (100)                               | -                                       |
| Guilt                                      | 28 (71)                                | -                                       |
| Attitude toward own abilities              | 18 (51)                                | -                                       |
| Attitude toward future                     | 17 (49)                                | -                                       |
| Goals                                      | 12 (34)                                | -                                       |
| Anxiety/hopes and ambitions                | -                                      | 18 (51)                                  |
| Conflicts regarding academics              | -                                      | 20 (57)                                  |

**Table 2: Clinical profile of patients (n=35)**

| Variables                                    | n (%) |
|----------------------------------------------|-------|
| Age (years)                                  |       |
| Mean                                         | 12.5  |
| Range                                        | 8-19  |
| Gender                                       |       |
| Male                                         | 20 (57)|
| Female                                       | 15 (43)|
| Diagnosis (ICD10)                            |       |
| Depressive disorder (F32)                    | 7 (20) |
| Neurotic and stress-related disorders (F40-F48) | 22 (63) |
| Behavioral and emotional disorders occurring in childhood and adolescence (F90-F98) | 6 (17) |
change in caste system, and social awareness such as feminism and globalization.[16] The patterns of family have also changed. The urban living has weakened joint family pattern and strengthened nuclear families[17] with increasing opportunities for new occupations and higher education. Female educational attainment and female employment participation have both risen,[18] possibly affecting children's development directly or indirectly through its effect on parenting styles or other aspects of family processes.[19] Overall, the changing social milieu may affect the quality of life and “subjective well-being” of children and parents. Research has demonstrated that low level of subjective well-being leads to poor mental health, increased depression, social isolation, emotional problems, and likelihood of victimization.[18-20]

The modified SCT was designed in such a way so as to target major aforementioned areas of overall adjustment in children and adolescents. The modification did elicit greater information complementing the clinical history, planning, and implementing management strategies such as individual psychotherapy, interpersonal psychotherapy, and family therapy. Hence, the importance of administering SCT as an important therapeutic and exploratory tool is stressed.

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Conflicts of interest
There are no conflicts of interest.

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