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**Cases**

**Fig-1:** Differences in overall subjective rating of the problems by the participants

**Fig-2:** Assessment of severity of the problems in pre – post intervention and follow up session by statistical scale of HADS

**Fig-3:** Assessment of severity of the problems in pre – post intervention and follow up session by statistical scale of GHQ-28

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**Empowerment**

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Bangladesh.
Job Performance of the Medical Representatives in Relation to Big Five Personality Factors

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and

Noor Muhammad

Department of Psychology
Jagannath university

Abstract
The present study was designed to investigate the relationship between job performance and big five personality factors. The big five personality factors are openness to experience, extraversion, agreeableness, conscientiousness and neuroticism respectively. Two hundred male medical representatives were selected by purposive sampling method as respondents in the present study. In order to measure big five personality traits and job performance, the Bengali versions of big five personality test and objective measures of job performance scale were administered on respondents respectively. Five hypotheses were formulated: (i) higher the openness to experience, more is the job performance; (ii) higher the conscientiousness, more is the job performance; (iii) higher the extraversion, more is the job performance; (iv) higher the agreeableness, more is the job performance; (v) lower the neuroticism, more is the job performance. The obtained data were analyzed by applying Pearson product method to determine the correlation coefficients among the variables. To consider the effect of big five personality factors on the respondents’ job performance, a stepwise multiple regression analysis is also carried out. The results of correlation matrix indicate that there are significant positive relationships of job performance with four factors (openness to experience, extraversion, agreeableness & conscientiousness) out of big five personality factors. Results also shows that there is a significant negative relationship of job performance with neuroticism. Results of stepwise multiple regression analyses suggest that agreeableness, extraversion and neuroticism are three predictors where extraversion is the strongest predictor which alone explains 9.5% variance as well as these three variables account for 30.9% variance in job performance. Thus, the findings of the present study confirm the formulated hypotheses.

Introduction
Personality is the pattern of enduring characteristics that produce consistency and individuality in a given person (Feldman, 2012). Personality encompasses the behaviors that make each of us unique and that differentiate us from others. Personality trait is a durable disposition to behave in a particular way in a variety of situations. Different psychologists have described the personality characteristics by traits theories. Psychologists McCrae and Costa (1987, 1997,
have identified five factor model of personality. McCrae and Costa maintain that most personality traits are derived from just five higher-order traits that have come to be known as the “Big Five”. These are extraversion, neuroticism, openness to experience, agreeableness, and conscientiousness. People who score high in extraversion are characterized as outgoing, sociable, upbeat, friendly, assertive and gregarious. Referred to as positive emotionality in some trait models, extraversion has been studied extensively in research for many decades (Watson & Clark, 1997).

Neuroticism people tend to be anxious, hostile, self-conscious, insecure and vulnerable. Openness is associated with curiosity, flexibility, vivid fantasy, imaginativeness, artistic sensitivity and unconventional attitudes. McCrae (1996) maintains that its importance has been underestimated. He argues that this trait is the key determinant of people’s political attitudes and ideology. People who score high in agreeableness tend to be sympathetic, trusting, co-operative, modest and straightforward. Those who score at the opposite end of this personality dimension are characterized as suspicious, antagonistic and aggressive. Agreeableness may have its roots in childhood temperament and appears to promote altruistic (helping) behavior in social interactions (Graziano & Eisenberg, 1997). Finally, conscientiousness people tend to be diligent, disciplined, well-organized, punctual and dependable. Conscientiousness is associated with higher productivity in a variety of occupational areas (Hogan & Ones, 1997).

Job performance refers to whether a person performs his job well. It is an extremely important criterion that relates to organizational outcomes and success. Coming from a psychological perspective, Campbell describes job performance as an individual level variable. That is, performance is something a single person does. This differentiates it from more encompassing constructs such as organizational performance or national performance which are higher level variables. Many industrial psychologists had shown their interest to conduct the study relating to big five personality factors and job performance considering their theoretical relationship. Two meta-analyses have summarized relations between each of the five dimensions and job performance (Hurtz & Donovan, 2000; Salgado, 2003). Both studies concluded that personality is associated with job performance, with conscientiousness being the best predictor. Furthermore, Hurtz and Donovan discovered that certain personality dimensions were correlated more strongly with performance for some jobs than others. Although mean correlations were not large, these studies provide evidence that personality is an important factor for job performance across different kinds of jobs. However, even stronger correlations can be found by closely matching the particular personality traits to the particular job and task (Tett, Steel &
Beauregard, 2003). For example, one might expect that emotional stability would predict performance in a job that requires the ability to handle stress, such as a police officer.

Many scholars have embraced the five-factor model of personality (FFM) as a replicable and unifying taxonomy of personality (Digman, 1990; Golberg, 1992). This model advances conscientiousness, agreeableness, extraversion, emotional stability, and openness to experience as five distinct traits that predict work attitudes and behaviors. Meta-analytic studies have shown that conscientiousness and emotional stability have been the most consistent FFM predictors of performance (Salgado, 1997), whereas other FFM constructs are relevant in specific jobs or criteria. Recent primary studies have indicated that personality tests can account for significant incremental validity beyond that accounted for by biodata (McManus & Kelly, 1999), mental ability (McHenry, Hough, Toquam, Hanson & Ashworth, 1990), assessment centers (Goffin, Rothstein & Johnston, 1996), and interviews (Cortina, Goldstein, Payne, Davison & Gilliland, 2000).

Workers high in conscientiousness are predisposed to be organized, exacting, disciplined, diligent, dependable, methodical and purposeful. Thus, they are more likely than low conscientiousness workers to thoroughly and correctly perform work tasks, to take initiative in solving problems, to remain committed to work performance, to comply with politics and to stay focused on work tasks. Recent research has revealed that managers perceive cognitive ability and conscientiousness as the most important attributes related to applicants’ hire ability (Dunn, Mount, Barrick & Ones, 1995). Barrick et al. performed a second-order meta-analysis of previous meta-analytic studies that examined personality-performance relationships and reported that conscientiousness was the only FFM construct to predict supervisory ratings of job performance across job and organizations.

Agreeableness (Hogan, 1986) or likability (Hogan, 1986), refers to such traits as selflessness, cooperativeness, helpfulness, tolerance, flexibility, generosity, sympathy and courtesy (Digman, 1990). However, agreeableness seems to be most relevant to job performance in situations in which joint action and collaboration are needed (Mount, Barrick & Stewart, 1998). Work contexts having a fairly high level of interpersonal interaction require selflessness, tolerance and flexibility. Agreeable persons tend to deal with conflict cooperatively or collaboratively, strive for common understanding and maintain social affiliations (Digman, 1990).

Barrick and Mount (1991) investigated the relation of the “Big Five” personality dimensions (extraversion, emotional stability, agreeableness, conscientiousness, and openness to experience) to three job performance criteria (job proficiency,
training proficiency, and personnel data) for five occupational groups (professionals, police, managers, sales, and skilled semi-skilled). Results indicated that one dimension of personality, conscientiousness, showed consistent relations with all job performance criteria for all occupational groups. For the remaining personality dimensions, the estimated true score correlations varied by occupational group and criterion type. Extraversion was a valid predictor for two occupations involving social interaction, managers and sales (across criterion types). Also, both openness to experience and extraversion were valid predictors of the training proficiency criterion (across occupations).

Other personality dimensions were also found to be valid predictors for some occupations and some criterion types, but the magnitude of the estimated true score correlations was small (p < .10). Overall, the results illustrate the benefits of using the five factor model of personality to accumulate and communicate empirical findings. The findings have numerous implications for research and practice in personnel psychology, especially in the subfields of personnel selection, training and development, and performance appraisal. Bing and Lounsbury (2000) conducted a study to examine the relationship of big five personality factors and job performance. Results indicated that openness and neuroticism are related to job performance. A stepwise hierarchical regression analysis revealed that openness predicted unique variance in job performance. They mentioned that openness and performance are positively correlated, but neuroticism and performance are negatively correlated.

**Rationale of the present study**

Previous studies indicate that big five personality factors are the significant predictors of the performance (Locke & Hulin, 1962). Jacobs and Solomon, (1977) also found that job performance is correlated with personality factors. So, it can be said that, from the literature, job performance is related to individual’s big five personality factors. But no mentionable study was conducted by the any researcher about this link in the context of Bangladesh. The present authors, considering the theoretical nature of this relationship among the variables (job performance and big five personality factors), is intended to conduct this study which may be helpful to all concerns with the management system of the organizations. Thus, the present study bears more important applied significance.

**Objective of the present study**

The major objective of the present study is to examine whether there is any relationship between big five personality factors and job performance.

**Hypotheses and their justification**

On the basis of the findings of previous studies, theoretical perspective and above discussion, the following hypotheses were formulated to test in this empirical study:
H1: Job performance is positively correlated with openness to experience

Openness to experience is related to scientific and artistic creativity (Feist, 1998), divergent thinking, low religiosity, and political liberalism (McCrae, 1996) that seem to be closely related to job performance. Furthermore, DeNeve and Cooper (1998) noted that "openness to experience is a 'double-edged sword' that predisposes individuals to feel both the good and the bad more deeply", rendering its directional influence on affective reactions like subjective well-being or job performance.

H2: Job performance is positively correlated with conscientiousness

Organ and Lingl (1995) argued that conscientiousness should be related to job performance because it represents a general work-involvement tendency and thus leads to a greater likelihood of obtaining satisfying work rewards, both formal (e.g., pay, promotions) and informal (e.g., recognition, respect, feelings of personal accomplishment). Indirectly, literature also suggests a positive relationship of conscientiousness with job performance (DeNeve & Cooper, 1998).

H3: Job performance is positively correlated with extraversion

Extraverts are predisposed to experience positive emotions (Costa & McCrae, 1992), and positive emotionality likely generalizes to job satisfaction and job performance, as demonstrated by Connolly and Viswesvaran's (2000) meta-analysis of PA-job satisfaction-job performance relationships. Evidence also indicates that extraverts have more friends and spend more time in social situations than do introverts and, because of their social facility, are likely to find interpersonal interactions (such as those that occur at work) more rewarding (Watson & Clark, 1997).

H4: Job performance is positively correlated with agreeableness

McCrae and Costa (1991) argued that agreeableness should be related to happiness because agreeable individuals have greater motivation to achieve interpersonal intimacy, which should lead to greater levels of well-being. Indeed, they found that agreeableness was positively related to life satisfaction, although at a relatively low. Assuming these same communal motivations exist on the job, then the same process should operate with respect to job performance.

H5: Job performance is negatively correlated with neuroticism

Because of their essentially negative nature, neurotic individuals experience more negative life events than other individuals (Magnus, Diener, Fujita, & Pavot, 1993) in part, because they select themselves into situations that foster negative affect (Emmons, Diener, & Larsen, 1985). To the extent that such situations occur on or with respect to the job, they would lead to diminished levels of job performance. Neuroticism has been described as the primary source of NA, and the link among NA, job performance was documented in Connolly and Viswesvaran's (2000) meta-analysis.
Method

Target Population
The target population of the present study was medical representatives who worked in the different medical college hospitals of Dhaka city in Bangladesh.

Sample and Sampling Technique
A total of 200 male medical representatives were used as respondents in the present study. The respondents were between 25 years to 40 years of age. Mean age of the respondents was 32.57 years (SD=9.63). Mean education span was 14.94 (SD=1.64). Mean of their job experience was 5.17 (SD=10.83). The respondents were selected by purposive sampling method.

Design of the study
The present study was conducted by following the cross-sectional survey research-design. This design indicates that all data were collected at a single point in time.

Measuring Instruments
1. The Big Five Personality Test
2. Objective measures of job performance

The Big Five Personality Test
In the present study the Bengali version of big five personality test (Muhammad et al., 2011) was used to measures the respondents’ big five personality factors. This test was originally developed by McCrae and Costa (1999). It contains 45 items. It has five dimensions such as openness to experience, conscientiousness, extraversion, agreeableness and neuroticism. There are nine items in each dimension and five alternative options to give answer in each statement. Among nine items four are negative and remain five are positive. The lowest possible score in each dimension is 9, highest possible score 45 and neutral point is 27. In the case of four dimensions (O, E, A, C) high score indicates positive symptoms of the personality characteristics and in the case of neuroticism, people who score high in neuroticism tend to be anxious, hostile and self-conscious.

The English and Bengali versions were administered on 50 participants with a gap of seven days. Significant correlations beween scores of English and Bengali versions indicated translation reliabilities of the scale. The correlation coefficients $[r \text{ (open)}= .93, P<0.01; r \text{ (cons)}= .83, p<0.01; r \text{ (extra)}= .82, P<0.01; r \text{ (agree)}= .91, P<0.01 \& r \text{ (neuro)}= .86, P<0.01]$ of both forms of big five personality factors were found significant. The test-retest reliabilities of the Bengali version of big five personality factors $[r \text{ (open)}= .87, P<0.01; r \text{ (cons)}= .82, p<0.01; r \text{ (extra)}= .90, P<0.01; r \text{ (agree)}= .86, P<0.01 \& r \text{ (neuro)}= .92, P<0.01]$ were also found significant.
To assure the content validity of a scale the Bangla version of the scale was given to Subject Matter Expert (SME), the Subject Matter Expert gave their essential remarks during the translation of the items from English to Bangla. Their essential remarks also assure the content validity of the adapted version of the scale. Finally, to assess the the construct validity of the scale correlation coefficients between score of each item and the total score of the scale were determined. The correlation coefficients \[ r\text{ (open)}=.94, P<0.01; r\text{ (cons)}=.86, p<0.01; r\text{ (extra)}=.84, P<0.01; r\text{ (agree)}=.79, P<0.01 \& r\text{ (neuro)}=.92, P<0.01 \]

**Objective measures of job performance**

For measuring job performance of the respondents we recorded their monthly productivity e.g., amount of sales as objective measures. Because objective measures are counts various behaviors (e.g., number of days absent from work) or the results of job behaviors (e.g., total monthly sales). In the present study the each of the respondent’s total monthly sales was recorded in their personal data sheet. By this way we have recorded all the respondents’ total monthly sales amount in their personal informational sheet. This measure indicates that if the respondents’ amount of monthly total sales is higher, their performance will be higher.

**Procedure of data collection**

In the present study ten different areas of Dhaka city were selected purposively as the study area to collect data. For collecting data the researcher went to the selected areas and met the respondents and had an informal talk with them in order to ensure a good rapport. After establishment of rapport, the researcher expressed the objectives of the study and also assured them the confidentiality of the responses. After that the respondents were requested to fill up personal information blank. When the personal information blank was filled up, the booklet of the Bangla version of the Big Five Personality Inventory and Objective measures of job performance were given to them. As the given Big Five Personality Inventory and Objective measures of job performance were given to the respondents. The respondents went through the instructions given on the front page of the booklet. Then the respondents were advised to start the task without wasting time. There was no limitation response time. But, one and half hours to two hours were needed to complete the total task. After the respondents had completed the task according to the instructions, the inventory booklet was collected from the respondents. Data from all the respondents were collected in individual session.

**Results**

In order to analyze the data zero order Pearson correlation and Stepwise Multiple Regression Analysis were applied on the obtained scores. According to the objectives the results of the study have been presented in three parts. For example, in the first part, mean and standard deviations of the six sets of scores were determined (Table-1).
Job Performance of the Medical Representatives in Relation to Big Five Personality Factors

**Table-1: Mean and Standard Deviation of the scores of the big Five Personality Factors and Job Performance**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean</th>
<th>Standard Deviation</th>
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<tbody>
<tr>
<td>Openness</td>
<td>29.53</td>
<td>4.55</td>
</tr>
<tr>
<td>Conscientiousness</td>
<td>31.65</td>
<td>4.41</td>
</tr>
<tr>
<td>Extraversion</td>
<td>30.92</td>
<td>4.67</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>28.26</td>
<td>5.33</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>26.20</td>
<td>4.52</td>
</tr>
<tr>
<td>Job Performance</td>
<td>79.17</td>
<td>10.86</td>
</tr>
</tbody>
</table>

Correlation matrix among the dependent and independent variables is shown in Table-2. To consider, in second part, the effects of each independent variable on job performance, a stepwise regression analysis is performed (Tables 3, 4, 5). Stepwise multiple regression permits the study of the relationship between a set of independent variables and a dependent variable, while accounting for the interrelationships among the independent variables. Here, first, the direct effect of each independent variable on job performance is estimated by the partial standardized regression coefficient with all over independent variables in the equation (Table-3). $R^2$ change is also calculated for determining the relative importance of each independent variable (Table-4). The joint effects of significant predictor variables on job performance are estimated by $R^2$ square (Table-4). The overall F-test is also performed for determining the joint influences of all independent variables to variation of job performance (Table-5).

**Table-2: Correlation Matrix among Openness, Conscientiousness, Extraversion, Agreeableness, Neuroticism and Job Performance**

<table>
<thead>
<tr>
<th>Variables</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Openness</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Conscientiousness</td>
<td>.490**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Extraversion</td>
<td>.528**</td>
<td>.533**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Agreeableness</td>
<td>.254**</td>
<td>.335**</td>
<td>.265**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Neuroticism</td>
<td>-.003</td>
<td>-.029</td>
<td>.015</td>
<td>-.415**</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>6. Job Performance</td>
<td>.275**</td>
<td>.285**</td>
<td>.345**</td>
<td>.415**</td>
<td>-.364**</td>
<td>-</td>
</tr>
</tbody>
</table>

** Correlation is significant at p<0.01 level (2-tailed) & * Correlation is significant at p<0.05 level (2-tailed)**

Simple correlations of each independent variable with dependent variable (such as the big five personality factors and job performance) are presented in Table-2. The results indicate that neuroticism is negatively correlated to job performance.
On the other hand openness, conscientiousness, extraversion and agreeableness is positively correlated to job performance. Results of table 2 further indicated that there were strong inter-correlations among independent variables.

**Table-3: Stepwise Multiple Regression of Job Performance on the Big Five Personality Factors**

<table>
<thead>
<tr>
<th>Independent variables</th>
<th>Standardized Beta</th>
<th>t</th>
<th>Sig.Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td></td>
<td>8.646</td>
<td>0.000</td>
</tr>
<tr>
<td>Agreeableness</td>
<td>.224</td>
<td>3.243</td>
<td>0.001</td>
</tr>
<tr>
<td>Extraversion</td>
<td>.290</td>
<td>4.607</td>
<td>0.000</td>
</tr>
<tr>
<td>Neuroticism</td>
<td>-.276</td>
<td>-4.135</td>
<td>0.000</td>
</tr>
</tbody>
</table>

**Dependent variable: Job Performance**

The partial standardized betas (βs) indicated that only thee variables in the model were predictors of job performance. These variables were agreeableness (β = .224, p<0.001), extraversion (β = .290, p<0.000 and naurtism (β = -.276, p<0.000). Thus, extraversion was the strongest predictor.

**Table-4: Selected statistics from Regression of Job Performance on the big Five Personality Factors**

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>R</th>
<th>R-square</th>
<th>R- square change</th>
<th>F-change</th>
<th>Sig. F</th>
</tr>
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<tbody>
<tr>
<td>Agreeableness</td>
<td>.415</td>
<td>.173</td>
<td>.173</td>
<td>410288</td>
<td>0.000</td>
</tr>
<tr>
<td>Agree. &amp; Extrversion</td>
<td>.308</td>
<td>.095</td>
<td>.095</td>
<td>20.779</td>
<td>0.000</td>
</tr>
<tr>
<td>Agree, Extra &amp; Neuroticism</td>
<td>.368</td>
<td>.309</td>
<td>.041</td>
<td>9.283</td>
<td>0.003</td>
</tr>
</tbody>
</table>

**Dependent variable: Job Performance**

Results of regression analysis indicated that strongest predictor of job performance was agreeableness which alone explained 17.3% variance. The results of the analysis further indicated that neuroticism was the second important predictor of job performance. R-square change indicated that 9.5% variance of job performance was accounted for by the extraversion. R-square indicated that these three variables account for 30.9% variance of job performance.

**Table-5: The overall F-test for Regression of Job Performance on the big Five Personality Factors**

<table>
<thead>
<tr>
<th>Source of Variations</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>Sig. F</th>
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<tr>
<td>Regression</td>
<td>6889.432</td>
<td>3</td>
<td>2296.477</td>
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<tr>
<td>Residual</td>
<td>16582.123</td>
<td>196</td>
<td>84.603</td>
<td>27.144</td>
<td>0.000</td>
</tr>
<tr>
<td>Total</td>
<td>234471.555</td>
<td>199</td>
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</table>

**Predictors: Agreeableness, Extraversion & Neuroticism**

**Dependent Variable: Job Performance**
The significant F-test \[ F (3, 196) = 27.144, p<0.000 \] of table-5 indicated that variation in job performance was accounted for by joint linear influences of agreeableness, extraversion & neuroticism.

**Discussion**

The present study was designed to investigate the relationship between job performance and the big five personality factors. In order to measure the respondents' personality traits and job performance two questionnaires were applied on two hundred medical representatives selected from different medical college hospitals in Dhaka city. The obtained data were analyzed by applying Pearson Product Method to determine the correlation coefficients among the dependent and independent variables which are presented in Table-2. To consider the effects of each independent variable on respondents' job performance, a stepwise regression analysis was also carried out. Results of regression analyses were presented in table 2 through 5.

Five hypotheses were formulated to test in the present study. The first hypothesis states that job performance is positively correlated with openness to experience. Result presented in Table-2 indicates that there is a significant positive relationship of job performance with openness to experience. These results are consistent with many investigators' research findings (Feist, 1998; McCrae, 1996; DeNeve & Cooper, 1998; Barrick & Mount, 1991).

The second hypothesis states that job performance is positively correlated with conscientiousness. Results presented in Table-2 indicates that there is a significant positive relationship of job performance with conscientiousness. This result is supported by the findings of the previous studies (Salgado, 2003; Costa & McCrae, 1980). They found that conscientiousness is the predictor in job performance. They mentioned that conscientious employees perform better and are more satisfied with their jobs because of the intrinsic and extrinsic rewards that high performance provides.

The third hypothesis states that job performance is positively correlated with extraversion. Result presented in Table-2 indicates that there is a significant positive relationship between job performance and extraversion. Standardized Beta (Table-3) also indicates that job performance is positively related to extraversion. The results of the analysis further indicated that extraversion was the strongest predictor of job performance. R-squire change indicated that 9.5% variance of job performance. This finding is consistent with Magnus et al., 1993; Barrick & Mount, 1991; Watson & Clark, 1997; Costa & McCrae, 1992; research findings. They claimed that extraverted employees are more likely to spend time in situations that make people happy.
Barrick and Mount (1991) mentioned that extraversion is a valid predictor for two occupations, managers and sales. Because extroverts are sociable, gregarious, talkative, assertive and active that lead to effective performance in jobs.

Fourth hypothesis states that job performance is positively correlated with agreeableness. Result presented in Table-3 indicates that there is a significant positive relationship of job performance with agreeableness. Standardized Beta (Table-3) also indicates that job performance is positively related to agreeableness. The results of the analysis further indicated that agreeableness was the second important predictor of job performance. R-square change indicated that 17.3% variance of job performance. This result is supported by the findings of Hogan, (1986); Mount, Barrick & Stewart, (1998); Digman, (1990); McCrae and Costa (1991). Organ and Lingl (1995) apparently agreed, commenting that agreeableness involves getting along with others in pleasant, satisfying relationship.

Fifth hypothesis of the present study was job performance is negatively correlated with neuroticism. Result presented in Table-2 indicates that there is a significant negative relationship of job performance with neuroticism. Standardized Beta (Table-3) also indicates that job performance is negatively related to neuroticism. Results of regression analysis indicated that strongest predictor of job performance was neuroticism which alone explained 4.1% of variance. This result is supported by the findings of Sackett and Wanek, (1996). They found that neuroticism is negatively correlated with job satisfaction.

Neuroticism refers to the tendency to experience negative feelings. Those who score high on neuroticism may experience primarily one specific negative feeling such as anxiety, anger, or depression, but are likely to experience several of these emotions. People high in neuroticism are emotionally reactive. They respond emotionally to events that would not affect most people, and their reactions tend to be more intense than normal. They are more likely to interpret ordinary situations as threatening, and minor frustrations as hopelessly difficult. A large number of researchers have found that big five personality factors are the significant predictors of job performance (Costa, & McCrae, 1980; Locke & Hulin, 1962). They found that some factors of big five personality factors are the predictors of job performance. So, in fine it can be said that the findings of the present study confirm our formulated hypotheses.

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Job Performance of the Medical Representatives in Relation to Big Five Personality Factors


Muhammad, N., Akter, S., & Uddin, E. (2011). *Adaptation of Big Five Personality Test for Use in Bangladesh*. Department of Psychology, Jagannath University, Dhaka


Job Performance of the Medical Representatives in Relation to Big Five Personality Factors


Maternal Rejection in Childhood: Its Effect on Self-esteem in Early Adulthood

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Abstract
The distorting effect of maternal rejection in childhood on the development of the type of self-esteem in early adulthood was investigated in the present study. In the light of literature review it was hypothesized that maternal rejection will be negatively correlated with self-esteem. In order to achieve this end, the study was conducted on 100 young adults (male=50, female=50) aged between 20-27 years, selected by using purposive sampling technique from Dhaka University. Following standard procedure, the measuring instruments used in this study were: (1) Demographic and Personal Information Questionnaire. (2) Adult Version of Parental Acceptance-Rejection Questionnaire: for mother which was originally developed by Ronald P.Rohner (1990, 2005), and adapted in Bangla by Jasmine, Uddin and Sultana (2007), (3) Bangla Version (Ilyas 2003) of Rosenberg’s Self-Esteem scale. Obtained data were analyzed by using mean, standard deviation, correlation co-efficient and regression analysis. Results confirmed the hypothesis. Correlation analysis indicated that maternal rejection had significant negative correlation with self-esteem. The value of adjusted $R^2$ of regression analysis indicated that maternal rejection is an important predictor which can explain 9.2% variance of self-esteem. The beta co-efficient showed that if we increase 1 standard deviation unit in maternal rejection, decreases .319 standard deviation unit in self-esteem. This result suggests that maternal rejection greatly influences their children’s personality development and mental health.

Introduction
A great deal of research has concentrated on the quality of parent-child relationship characterized by parental (paternal as well as maternal) acceptance (love) and rejection (lack of love). The conducted researches report that parental (paternal as well as maternal) acceptance-rejection is a major predictor of psychological functioning and different aspects of personality development for both children and adults universally (Khaleque and Rohner, in press; Rohner, 1975, 2002, Rohner and Rohner, 1980). The empirical study of parental acceptance-rejection has a history going back

The main theme of Parental Acceptance-Rejection Theory described by Rohner et al. is that feeling cared by one’s attachment figure may have more consistent and universal effects on individual’s psychological well-being than any other single class of experience (Rohner, Khaleque, and Cournoyer, 2007).

Parenting or child rearing is the process of promoting or supporting the physical, emotional, social, and intellectual development of a child from infancy to adulthood (Davies, 2000). It is a lifelong process. The term “Parent” is defined in PAR Theory as any person who has a more or less long-term care giving responsibility for a child. From biological perspective, a mother (or mum/mom) is a woman who has raised a child, given birth to a child, and/or supplied the ovum that united with a sperm which grew into a child.

During the 1960s, psychologist Diana Baumrind conducted a study on more than 100 pre-school age children (Baumrind, 1967) by using naturalistic observation, parental interviews and other research method; she identified four important dimensions of parenting: 1. Disciplinary strategies, 2. Warmth and nurturance, 3. Communication styles and 4. Expectations of maturity and control. Based on these dimensions, Baumrind suggested that the majority of parents display one of the three different parenting styles: Authoritarian parenting style, Authoritative parenting style and Permissive parenting style. Further research by also suggested the addition of a fourth parenting style (Maccoby & Martin, 1983) that is known as uninvolved parenting style.

Based on the dimensions of “parental responsiveness” and “parental demandingness”, developmental psychologist Diana Baumrind concludes that: the uninvolved parenting style is low in parental responsiveness (the nurturing aspect of the child) and low in parental demandingness (control over the child).

Parental acceptance-rejection is measured by different types of parenting styles. The Parental Acceptance-Rejection theory (PAR Theory) formulated by Ronald P. Rohner (Rohner, 1975, 1986, 2002) attempts to answer five
classes of questions divided into three sub-theories such as: Personality sub-theory, coping sub-theory and Socio-cultural systems sub-theory. Much of the life span perspectives are incorporated into PAR Theory’s personality sub-theory, which actually attempts to explain and predict major personality or psychological-especially mental health related consequences of perceived parental acceptance and rejection by asking two general questions. The present study was conducted to find out the answer of the second question of personality sub-theory of PAR Theory by measuring the degree of effects of childhood maternal rejection on self-esteem in early adulthood.

The concept of personality is defined in personality sub-theory as an individual’s more or less stable set of predispositions to respond (i.e., affective, cognitive, perceptual, and motivational dispositions) and actual modes of responding (i.e., observable behaviors) in various life situations or context. According to the sub-theory individuals who feel rejected are likely to be anxious and insecure, as well as to develop all or most of the following personality dispositions: (1) Hostility, aggression, passive aggression, or problems with the management of hostility and aggression; (2) dependency or defensive independence depending on the form, frequency and severity of perceived rejection; (3) Impaired feelings of self-esteem and self-adequacy; (4) Emotional unresponsiveness and instability; and (5) a negative worldview. Together, parental acceptance and rejection form the warmth dimension of parenting on which all humans can be placed because everyone has experienced in childhood more or less love at the hand of major caregivers. One end of the continuum is marked by parental acceptance, which refers to the warmth, affection, care, comfort, concern, nurturance, support, or simply love that children can experience from their parents and other caregivers. The other end of the continuum is marked by parental rejection, which refers to the absence or significant withdrawal of these feelings and behaviors and by the presence of a variety of physically, and psychologically hurtful behaviors and affects.

Parental acceptance-rejection can be studied as perceived or subjectively experienced by the individual (the phenomenological perspective), or it can be studied as reported by an outside observer (the behavioral perspective). In the present study, maternal rejection is measured by the phenomenological perspective, because a child may feel unloved (as in undifferentiated rejection) but outside observers may fail to detect any explicit indicators of maternal rejection.
Mother’s interactions tend to affect unique aspects of her children’s development than father’s interaction, because a child passes more time with his/her mother than father. It is generally the mother who naturally and practically remains the biggest source of love, affection, guidance, care, supervision, inspiration and motivation to the child in general and during childhood in particular. So, maternal rejection in childhood manifests in the early adulthood in the form of excessive fear, shyness, aggressiveness, anxiety, depression, slow conscience development, low self-esteem, feeling of insecurity, loneliness etc.

In the mid 1960s, Morris Rosenberg a social-learning theorist defined self-esteem in terms of a stable sense of personal worth or worthiness. Generally there are two types of self-esteem: implicit self-esteem and explicit self-esteem. People can also develop the types of self-esteem as high self-esteem, low self-esteem and inflated self-esteem.

Adulthood, the period in the human life span in which full physical and intellectual maturity have been attained. A young/prime adult, according to Erik Erikson’s stages of human development, is generally a person aging from 20 to 40.

Since the 1930s a large number of studies have been conducted on the antecedents and especially the consequences of perceived parental acceptance-rejection for cognitive, emotional, and behavioral development of children and for personality functioning of adults within United States and worldwide. An especially productive early collection of acceptance-rejection research papers came from the Fels Research Institute in the 1930s and 1940s (Baldwin, Kalhorn, & Breese, 1945, 1949). During the 1930s and 1940s the Smith College studies in social work also produced a long and useful series of research chapters on the effects of parental acceptance-rejection (Witmer, Leach & Richman, 1938). In an extensive study on children, Cooper Smith (1967) found that high self-esteem was related to “authoritative pattern of parenting.”

Buri (1987) found that parental acceptance, approval and support were positively related to self-esteem. Studies have linked self—esteem to patterns of child rearing, Bishop and Ingersoll (1989) found that warm responsive parenting is linked to high self-esteem. In an extensive study on children, Cooper Smith (1967) found that high self-esteem was related to “authoritative pattern of parenting.”
Strong evidence supports PAR Theory’s expectations that children who come from loving (accepting) families are more likely than children who come from unloving (rejecting) families to feel good about themselves, feel competent, have less problems with the management of hostility and aggression, have adequate emotional responsiveness and emotional stability, have less dependence and have a positive world view (Kim & Rohner, 2002, 2003; Rohner, 2004).

Rationale of the study

Very few empirical investigations are available from Bangladeshi context to highlight the relationship between maternal acceptance-rejection and children’s personality development. Adulthood is a period of adjustment and people have to face new life pattern, play new role and form new identity in this new stage of life. Healthy personality development helps them to handle these new situations effectively. A person passes more time with his/her mother than father. So, maternal acceptance or rejection plays a more significant role than paternal acceptance or rejection on children’s personality development. Therefore, the present study is an attempt to explore the relationship of maternal rejection with self-esteem, which is one of the major predictors of personality development. Hopefully, the parents will get information about the negative impact of maternal rejection on children’s personality development and will understand the parents’ appropriate parenting behavior with their offspring to help in developing a desired personality pattern. Furthermore, the study will be able to enrich the PAR Theory’s personality sub-theory.

Objective of the Present Study

The objective of the present study is to investigate the relationship of maternal rejection with self-esteem in early adulthood.

Hypothesis

Considering the above objective, the following hypothesis was formulated: Maternal rejection will be negatively correlated with self-esteem.

Method

Sample Characteristics

The study sample consisted of 100 young adults. Among them 50 were male and 50 were female. The age of the respondents ranged from 20 to 27 years. They were selected purposively from the University of Dhaka. Their educational qualification ranged from graduation to master’s level.
Sampling Criteria

One criterion used for selecting the adult respondents of the present study was that they lived with their mother at childhood (7-12 years).

Instruments of Measurement

In the current study, the following instruments were used to collect data:
- **Demographic and Personal Information Questionnaire**: A Demographic and Personal Information Questionnaire was used to collect personal information about sex, age, number of siblings, birth order, educational qualification, mother’s occupation, mother’s educational status, monthly family income and socio economic status of the respondents.
- **Adult Version of Parental Acceptance-Rejection Questionnaire**: for mother, originally developed by Ronald P. Rohner (1990, 2005) and adapted in Bengali by Jasmine, Uddin and Sultana (2007): The mother Version of the PARQ/Control was originally Developed by Rohner (1990, 2005) and adapted in Bengali by Jasmin, Uddin & Sultana (2007). It is a self-report and four point Likert type measure consisting of 73 items. It was designed to assess individual’s perception of maternal acceptance or rejection. Each version consists of five sub-scales. Four sub-scales (60 items) measured respondent’s perceptions of maternal Warmth/Affection (20 items), Hostility/Aggression (15 items), Indifference/Neglect (15 items) and Undifferentiated /Rejection (10 items). A fifth sub-scale of 13 items was not used here, which measures perceived maternal control (Permissiveness/Strictness).

Reliability and Validity of the Scale

Split half reliability co-efficient of Adult PARQ for mother was found .89. Cronbach’s Alpha co-efficient of the scale was found .92. The Adult PARQ for Mother had face validity, Discriminant validity and predictive validity and were internally consistent found in item analysis. The content validity of Adult PARQ for mother was determined by the relevant experts according to their comments and recommendations.

Scoring

The respondents were given 4 for “almost always true”, 3 for “sometimes true”, 2 for “rarely true” and 1 for “almost never true” in case of positive (retained) items. The reverse scoring was made in case of negative (reverse coded) items. Scores on the four acceptance-rejection sub-scales were summed which produced an overall measure of perceived maternal acceptance-rejection that ranged from a low of 60 (maximum perceived acceptance) to a high of 240 (maximum perceived rejection). The Adult PARQ for mother is similar to the father version in every respect except
that, instead of father it reflects remembered acceptance-rejection of one’s mother. The ideal form of the Adult PARQ is designed conceptually in such a way that scores at or above 150 reveals the experience of significantly more rejection than acceptance. Scores between 140 and 149 reveal that respondents experienced high level of rejection, but not more overall rejection than acceptance. The intermediate scores of 121 to 139 reveal the feelings of increasing but not get serious love withdrawal (rejection). On the other hand, scores between 60 and 120 reveal individual’s maternal love.

Bengali Version (Ilyas, 2003) of Rosenberg’s Self-esteem Scale: The Bengali Version (Ilyas, 2003) of Rosenberg’s Self-esteem Scale was originally developed by Morris Rosenberg (Rosenberg, M.1965). It is a Likert type scale with 10 items answered on a four point scale from strongly agree to strongly disagree. Five of the items have positively worded statements and five have negatively worded ones. The scale measures state of self-esteem by asking respondents to reflect on their current feelings.

Reliability and Validity of the Scale

The scale is highly reliable: test-retest correlations are typically in the range of .77 to .88 (Blascovich & Tomaka, 1991) .Significant correlations of English and Bengali Version ($r_{48}=.87, P<.0005$) indicated translation reliability of the Bengali version of the Scale (Ilyas, 2003).High Cronbach’s alpha ($\alpha=.87$) of Bengali version further indicated internal consistency of the scale (Ilyas, 2003).

Data from different samples involving a total of 1,044 male and female German adults (cancer patients, relatives of cancer patients, medical staff working with cancer patients and old adults) indicate that the RESE has satisfactory criterion and convergent validity and is not very sensitive to situational variations in self-esteem.

Scoring

The Scale is a 10 item Likert scale with items answered on a four point scale- Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD). The score given for SA=3, A=2, D=1 and SD=0. Items with an asterisk (2, 5, 8, 9, and 10) are reversed scored. That is SA=0, A=1, D=2 and SD=3. Then the scores of the 10 items are summed together. The higher the score, the higher the self-esteem.

Procedure
Standard procedure was followed in the study to collect data from the students of Dhaka University. At the beginning, participants were briefed about the general purpose of the study and good rapport was established with them. They were informed that the investigation was purely academic and their responses to the questionnaires would be kept confidential. Then the above instruments were administered individually to the members of the sample. Prior to responding the items, participants were requested to make a silent reading of the standard instructions printed on the questionnaire. Along with this, they were given also verbal instruction. The respondents were told to read the items of the scales attentively and to respond carefully. All necessary clarifications were made regarding the items. They were asked to give tick (✓) mark in the appropriate box. They were also requested not to omit any item in the questionnaire and told that there was no right and wrong answer and no time limit for answering. Generally, each participant took 20-25 minutes to fill up the questionnaires. After completion of their task, the questionnaires were collected and they were given thanks for their sincere cooperation. All data were collected within one month.

Data Processing and Statistical Analysis

The responses of the participants were scored according to the scoring system of adult Bengali version of PARQ for mother and Bengali version of Rosenberg’s self-esteem scale. Each participant received an average maternal rejection score and self-esteem score. To achieve these scores field data were assembled, coded and recorded. Then the data were input into SPSS (Statistical package for social sciences). After processing the data analysis format, the data were analyzed through the help of SPSS program. As the present research was co-relational in its nature, the obtained data were analyzed by simple regression using maternal rejection as predictor variable and self-esteem as criterion variable, to see the relationship of maternal rejection with self-esteem in early adulthood. Mean and standard deviation of the above variables according to gender were also measured.

Results

The purpose of the present study was to investigate the relationship of maternal rejection with self-esteem in early adulthood. Collected data were analyzed by computing mean, standard deviation, correlation co-efficient and simple regression analysis.

Table-1: Mean and standard deviation of total maternal rejection score based on the sub scale scores of both male and female young adults.
Table 1 shows the mean and the standard deviation of PARQ score: for mother based on the subscale scores (M=132.00 and SD=21.08, for male) and (M=123.96 and SD=20.85 for female). It reveals the felt maternal rejection of male and female participants.

![Total PARQ Mean](image)

**Figure-1:** Histogram of total maternal rejection score based on the subscale scores of both male and female young adults.

Table 2: Mean and Standard Deviation score of self-esteem score of both male and female young adults.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Participant’s gender</th>
<th>Number</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>Male</td>
<td>50</td>
<td>18.92</td>
<td>4.37</td>
</tr>
<tr>
<td></td>
<td>Female</td>
<td>50</td>
<td>17.98</td>
<td>4.14</td>
</tr>
</tbody>
</table>

Table 2 indicates the mean and the standard deviation of self-esteem scores of male and female young adults (M=18.92 and SD=4.37, for male) (M=17.98 and SD=4.14, for female) which tended to be of medium level of self esteem.

![Self Esteem Mean](image)

**Figure-2:** Histogram of self-esteem score of both male and female young adults.
Correlation Co-efficient

Table-3: Correlation co-efficient of self-esteem with the subscale scores of PARQ: for mother and total maternal rejection scores based on the sub scale scores

<table>
<thead>
<tr>
<th>Variable</th>
<th>Reverse Warmth/Affection</th>
<th>Hostility/Aggression</th>
<th>Indifference/Neglect</th>
<th>Undifferentiated/Rejection</th>
<th>Total maternal rejection score based on subscale scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>-0.353**</td>
<td>-0.278**</td>
<td>-0.171</td>
<td>-0.309**</td>
<td>-0.319**</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed)

Results of correlation analysis shown in Table: 3, indicates that self-esteem has significant negative correlation with Reverse Warmth/Affection score (r=-0.353, **p≤ 0.01), Hostility/Aggression score(r=-0.278, **p≤ 0.01), Undifferentiated/Rejection score (r=-0.309, **p≤ 0.01) and total Maternal rejection score based on subscale scores (r=-0.319, P≥10.0). It also indicates that self-esteem has negative correlation with Indifference/Neglect score (r=-0.171), but the correlation is not significant.

Regression analysis

Table-4: Regression of Self-esteem on total maternal rejection score based on the Sub-scale scores

<table>
<thead>
<tr>
<th>Predictor variable</th>
<th>Unstandardized co-efficient</th>
<th>Standardized co-efficient</th>
<th>t</th>
<th>p</th>
<th>r_p (Part correlation)</th>
<th>r_p²x100</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>26.643</td>
<td>2.495</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total maternal rejection score based on the sub-scale scores</td>
<td>-0.064</td>
<td>0.019</td>
<td>-3.328</td>
<td>.001</td>
<td>-0.319</td>
<td>31.9</td>
</tr>
</tbody>
</table>

In Table-4, total maternal rejection score based on the sub-scale scores was the predictor variable and self-esteem was the criterion variable. The value of standardized beta (β=-0.319) reveals that 1 standard deviation unit increases in total maternal rejection score based on the sub-scale scores decreases 0.319 standard deviation unit in self-esteem. Table 4 also indicates (Adjusted R²=0.092, F₁, ₉₈ =11.074, P≤ 0.001) that the predictor variable or total maternal rejection score based on the sub-scale scores can explain 9.2% variance of criterion variable or self-esteem. Furthermore, the value of part correlation in the above table indicates that the unique
contribution to the explanation of variance in total maternal rejection score based on the sub-scale scores is 31.9%.

The estimated regression co-efficient (intercept and slope) given in Table-4 indicates from the estimated value of self-esteem (B=26.643) that if the value of total maternal rejection score based on the sub-scale scores is kept constant, then the value of self-esteem is 26.643 on an average. Besides this, the estimated value of self-esteem (B=-0.064) implies that if we increase one unit in total maternal rejection score based on the sub-scale scores, then the value of self-esteem decreases 0.064 unit.

Discussion

The present study attempted to investigate the relationship of maternal rejection with self-esteem in early adulthood. Consistent with the previous findings in different cultures, the results of this research identified maternal rejection as a good predictor of self-esteem in early adulthood in which self-esteem had significant negative correlation (r = - .319**, P ≤ .01) with remembrance of maternal rejection in childhood. This means that the more the children perceive their mother rejecting, the less the self-esteem. The results confirmed the formulated hypothesis that maternal rejection in childhood will be negatively correlated with self-esteem in early adulthood. The result supported the previous study of Forsman (1989), who investigated the relationship between parental (paternal as well as maternal) unconditional positive regard and adult self-esteem and found that higher parental (Paternal as well as maternal) unconditional positive regard was related to higher self-esteem in both men and women. The value of standardized beta co-efficient (β = - .319, P < .001) indicated that a change of 1 standard deviation unit in maternal rejection resulted in a change of .319 standard deviation unit in self-esteem. The value of adjusted R² in Table-4 (adjusted R² = - .319. F = 11.074, P < .001) means that maternal rejection could explain 9.2% variance of self-esteem. So, we can say that maternal rejection was influential for the variation of self-esteem. The unique contribution of maternal rejection was 31.9% (Table-4). The result suggested that maternal rejection was a predictor of self-esteem. This conclusion is demonstrated by the fact that having a loving relationship with mother in childhood appears to act as a protective buffer in the context of many serious psychological effects (Rohner and Khaleque, 2005). Along with this, maternal acceptance provides a child with the feelings of belongingness, security, and confidence that help adjust psychologically at different stages of life. It is assumed that this is true to people all over the world despite differences in culture.
Limitations of the study

Although the present study tried to maintain a sound methodology and analysis of collected data, nevertheless it is not free from certain limitations. First, this work was conducted only with the relationship between mother and children. It remains unclear whether the same conclusion as reported here holds true in relation to paternal rejection. Secondly, the sample was selected only from Dhaka University and it was only students. So, the sample was not representative. Thirdly, sample size was too small that it was inadequate to reach at a definite conclusion. Fourthly, the administered questionnaire was too long. So some participants might have answered the questionnaire inattentively. Finally, some participants may not have expressed their feelings properly. Self-report questionnaires are subject to bias and the accuracy of reports cannot be verified.

Implications of the study

Despite limitations, the present study makes some important contribution to different areas. First, by uncovering the fundamental role of maternal rejection on children’s personality development, the present study makes psychologists to understand and respond to the relation between maternal rejection and self-esteem of their children. Secondly, the present study is likely to contribute to maternal behaviors, so that children perceive their parents to be accepting. For this reason, it is important to increase the availability of special programs, such as, parenting effectiveness training, a variety of sophisticated books, make policies and programs of prevention, intervention and treatment. Thirdly, professionals seeking improvement of the general psychological well-being of young adults may use the results of this study to consider evidence-based interventions aimed at increasing self-esteem. Finally, the finding of this research that maternal rejection can predict 9.2% variance of self-esteem of young adults is expected to generate further interest in this area of research. Furthermore, hopefully, this study will contribute to the enrichment of the existing PAR theory by providing more information about the relationship of maternal rejection with self-esteem, in the context of Bangladesh.

Concluding remarks

The present study provides empirical evidence of mother’s contribution in child’s personality development. As children grow older, the components of their personality development take a final shape. The close affectional bond between mothers and their children forms the core of family relationship. Because of high level of father’s psychological non-
availability and non-despite involvement in Bangladeshi child rearing, generally mothers spend more time with children than do fathers. For this reason, children may become less attentive to their father’s behavior than to mothers. As a result, mother’s rejecting behaviors in childhood (7-12 years) have a significant impact on self-esteem in early adulthood. Certain deviation in maternal behavior at the age of 7 to 12 years can have profound effects on children’s subsequent abilities to cope with challenges of life and healthy personality development.

Recommendations

The study recommends further in-depth research in this area on a large and representative sample from different socio-economic backgrounds and from different areas of Bangladesh which should be designed as to find out more variables playing a significant role which may help to take proper measures for this vulnerable age group (7-12 years) to become healthy and happy individual and thus be the resource of the society.

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Validation of the Foreign Language Classroom Anxiety Scale

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Abstract

The Foreign Language Classroom Anxiety Scale (FLCAS) is an instrument that has been used to identify Anxiety patterns in a student's Foreign Language Classroom Anxiety. The present study aimed at adapting the Foreign Language Classroom Anxiety Scale (Horowitz, 1986) in Bangla. The FLCAS comprises four self-report measures namely Communication Apprehension, Fear of Negative Evaluation, Test Anxiety and Anxiety of Foreign Language Classes. These sub scales give an overall anxiety measure which indicates Foreign Language Classroom Anxiety. A total of 125 students of ages between 17 to 23 years completed the FLCAs. Both Internal consistency and test retest reliabilities were highly satisfactory. Significant correlations between the inventories provided the evidence for construct validity. Cronbach alpha 0.881, Subscale reliability CA .678, FNE .676, TA .494 and AFLC .746 was found to be significant. Validation of the scale was assured by Content validity and Construct validity, where Construct validity included Item analysis. Satisfactory level of validity was found for the Bangla version of FLCAS. Significant correlations between the inventories provided the evidence for construct validity. Thus, the Bangla FLCAS was found culturally appropriate.

Introduction

This study is an adaptation of FLCAS (Horwitz et al. 1986). Adaptation of psychological instruments is used in current research as they are well recognised for maximizing cultural appropriateness and lack of bias. The term ‘adaptation’ is used for any procedure in which an instrument that is developed for one language and cultural group is transferred for usage in another language and cultural group. It is different from the traditional concept of translation because it does not only produce a linguistically equivalent version in another language but takes into account different cultural issues as well.

Professionals assessing foreign language classroom anxiety of university students apply a host of standardized instruments. Unfortunately, this
practice is lacking in Bangladesh. Rather, the professionals depend mostly on their observations. It is well documented that self-report measures give clearer picture of anxiety of the students than other measures (by Horwitz, Horwitz, and Cope, 1986). Therefore, self-report of students can provide very important information for making effective treatment and intervention plans (Horwitz, Horwitz, and Cope, 1986; MacIntyre and Gardner, 1991).

The Bangla version of the Foreign Language Classroom Anxiety Scale is used for non-clinical purposes. For example, the scale can be used in school setting to screen problems such as anxiety symptoms. These inventories can assist in early interventions for students who are likely to develop serious Foreign Language Classroom Anxiety which in turn may impair their ability to function in the university settings. Therefore, the FLCAS has been adapted for use in Bangladesh.

Horwitz et al. (1986) developed the most commonly used tool for assessing the Foreign Language Classroom Anxiety Scale (FLCAS) which was used as a research tool to determine the students’ foreign language anxiety level. Numerous researchers (Horwitz et al., 1986; Young, 1990) concur that anxiety in foreign language learning manifests itself primarily in listening and speaking in the foreign language. The FLCAS comprises of 33 items with individual self-report Likert scale.

There are three main types of foreign language anxiety on which all practitioners agree:

1. Communication apprehension
2. Test anxiety
3. Fear of negative evaluation

1. Communication Apprehension

Communication apprehension is a type of shyness characterized by fear of and anxiety about communicating with people. Difficulties in speaking in public, in listening or learning a spoken message are all manifestations of communicative apprehension. Communication apprehension in foreign language learning derives from the personal knowledge that one will almost certainly have difficulty understanding others and making oneself understood; that is why many talkative people are silent in the class.

2. Test anxiety
Test anxiety refers to a type of performance anxiety stemming from a fear of failure. Test anxious students often put unrealistic demands on themselves. Test anxiety is believed to be one of the most important aspects of negative motivation. It can be defined as “unpleasant feeling or emotional state that has physiological and behavioral concomitants and that is experienced in formal testing or other evaluative situations” (Dusek, 1980). Various studies show that test anxiety is a problem for both boys and girls and for middle and working class children from all major socio-cultural groups (Hill and Wigfield, 1984).

3. Fear of negative evaluation

Fear of negative evaluation, apprehension about others’ evaluations, avoidance of evaluative situations and the expectation that others will evaluate them negatively is the third type of anxiety. It may occur in any situation; learners may be sensitive to the evaluations-real or imagined- of their peers.

Rationale of the study

Today, knowledge of English language is a necessity for all and sundry. It is a language that people cannot do without. So, it is important for the students of Bangladesh to learn this language well if they wish to make a better place for themselves in the job market in this time of competition. However, it has been observed that many of the students in English language classrooms experience anxiety that results in fast heart-beating and stuttering. Considering the importance of English language learning in our educational arena the need of a measure of Foreign Language classroom anxiety is imperative. Yet it is not quite possible for researchers to measure students’ anxiety using the original scale in English due to the prevailing conditions of students. If the original scale is administered on the students, they will be anxious imperfections the results of the research. Thus, the researchers of the present study decided to adapt the original version of the Foreign Language Classroom Scale into Bangla. Students will feel comfortable when the Bangla scale is administered on them. As a result, the adapted Bangla version of the scale can help to identify Foreign Language Classroom Anxiety more accurately.

Objectives of the present study

The objective of the present study was to adapt the Foreign Language classroom Anxiety Scale (Horowitz, 1986) for use in Bangladeshi context.
Job Performance of the Medical Representatives in Relation to Big Five Personality Factors

Method

Sample

This research was conducted on a sample (Field Test) of 125 students recruited from the capital city, Dhaka. It is mentionable that all participants spoke Bangla as their first language (L1). They were all tertiary level students who had studied in Bangla medium so far. They had all studied English as a compulsory but foreign language subject. These students were studying different languages which are L2 (foreign language) for them. All participants had been taken on the basis of purposive sampling technique. The details of the sample characteristics are shown in Table 1 below.

Table-1: Distribution of respondents by selected demographic, personal, and social variables

<table>
<thead>
<tr>
<th>Phase</th>
<th>Total Participants</th>
<th>Gender</th>
<th>Foreign Language</th>
<th>Age of Participants(Years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Male (%)</td>
<td>Female (%)</td>
<td>English (%)</td>
</tr>
<tr>
<td>1st Phase (Pre-testing I)</td>
<td>55</td>
<td>38 (69.1)</td>
<td>17 (30.9)</td>
<td>20 (36.4)</td>
</tr>
<tr>
<td>2nd Phase (Pre-testing II)</td>
<td>80</td>
<td>48 (60.0)</td>
<td>32 (40.0)</td>
<td>56 (70.0)</td>
</tr>
<tr>
<td>Final Phase (Field test)</td>
<td>125</td>
<td>78 (62.4)</td>
<td>47 (37.6)</td>
<td>104 (83.2)</td>
</tr>
</tbody>
</table>

Note: Numbers in Parentheses represent Percentages.

The adaptation process of the FLCAS consisted of the following six steps:

**Step one: Ensuring construct equivalence**

To determine whether the constructs namely Foreign Language Classroom Anxiety Scale (FLCAS) have the same meaning in Bangladeshi culture as in American culture, available literature on these constructs published in different scientific journals and books written by Bangladeshi psychologists have been reviewed. Also, the judgments of experts from the Department of Psychology, University of Dhaka, have been taken about construct equivalence between the two cultures. It appeared convincing from literature review along with expert opinion that equivalence of the
constructs under study does exist and same definition equally applies to language and cultural group of Bangladesh.

**Step two: Forward translation**

Three translators were selected who first (without consulting one another) independently translated the English version inventories to Bangla. Their mother tongue was Bangla, their medium of education was English, and they were familiar with American language and culture. They were very knowledgeable about the principles of test adaptation and were well conversant with the constructs being measured. Then the translators worked together with their respective translated versions and selected the best words, expression, or items by arriving at a consensus. Thus, the preliminary Bangla version inventory was prepared. A teacher of the University of Dhaka was requested to check the language structure and quality of translation, and conceptual equivalence of words or phrases, but not a word-for-word translation. Modifications of some words, expression, or items were made following his suggestions.

**Step three: Back translation**

A teacher of Psychology, proficient in both English and Bangla language, was entrusted with the task of translating the Bangla version into English. A panel consisting of three psychologists having expertise in psychology and proficiency in English judged the equivalence of the original English version and the translated version of the inventories. There was perfect agreement among the panel members that the FLCAS-translated version of the inventories was very much like the original one indicating the correctness of forward translation. The Bangla version was then subjected to subsequent processes.

**Step four: Pre-testing I and cognitive interviewing**

The first pre-testing was carried out by administering the Bangla version inventories on a group of convenience sample of 55 students of ages 18 to 24 years. The students were informed of the objectives and significance of the research. Only the students who showed interest to participate were selected. Three methods namely inventory administration, interview, and item analysis were used to get primary validity evidence for each item.

Inventory administration: An examiner, trained in assessment procedure, administered the inventories on the respondents in a classroom. At first, the students were asked to read the instructions on the top of the inventory
very carefully. Also the examiner orally explained what was to be done, emphasizing that there were no right or wrong answers. The examiner directed the student to answer every question honestly and to select only one response for each question. The students responded to each item by indicating how frequently the statement was true for them. During the test, they were allowed to ask questions about words or concepts which they did not understand. The words or expressions that the student asked about were noted by the administrator to check whether it was necessary to modify them. Students were allowed to change responses but it was made sure that the original response was completely erased.

Interview: Individual interview method was used to check whether any word, concept, or expression were found confusing, difficult, unacceptable or offensive. For some items there were several possible alternative words or expressions. In these cases the students were asked to choose the best option.

Item analysis: Students’ responses in each inventory were analyzed to determine corrected item-total correlation which indicated the appropriateness of each item. Negative or low correlation of an item score with total score in an inventory indicates that the item is defective in measuring what the whole inventory is supposed to. Item analyses for each inventory separately revealed that a total of 08 items had low positive correlation with total score. However, internal consistency reliability (alpha coefficient) for each inventory was very high ranging from .872 to .881. Interestingly, these were the items which the respondents criticized. The remaining 25 items had significant and acceptable correlation with total score. The panel of psychologists who worked in the back translation phase had modified the language of the faulty items which resulted in the revised preliminary Bangla Version of Foreign Language Classroom Anxiety Scale (FLCAS).

Step five: Pre-testing II

Second pre-testing was carried out to check the validity of the items of revised preliminary Bangla Version of Foreign Language Classroom Anxiety Questionnaire. In this phase two methods were followed: inventory administration and item analysis.

Inventory administration: The inventories were administered to a purposive and conveniently selected sample of 80, students of ages between 16 to 23
years. Data were collected following the same procedure used during inventory administration for the first pre-testing.

Item analysis: Corrected item-total correlation coefficients were highly satisfactory for items of each inventory and internal consistency reliability (alpha coefficient) for each inventory ranged from .866 to .876. The coefficients are comparable to those of the original English version inventories.

**Step six: Field test**

The field test was carried out to determine reliability and validity of the Bangla Version of Foreign Language Classroom Anxiety Scale. We used purposive and convenience sampling techniques to collect data from 125 students aged 17 to 23 years. Among them 78 were male and 47 were female. First, the testing was carried out conveniently in class rooms with kind permission from and cooperation of Language Institution authorities. We collected data from the students who were available and willing to participate in the study. Second, though many students were available, we purposively included in our sample only those who met three inclusion criteria: (a) studied at Bangla medium schools (b) learning at least one foreign language, and (c) had no severe physical or mental condition that might interfere with the assessment.

The students were informed of the purpose of the study and they were told that their name would not appear on the tests, and the responses would be anonymous. Trained research assistants administered the inventories following a detailed testing protocol. The number of students at test sites varied depending on the number of students available on the testing day.

At the beginning of administration the examiner read the instructions aloud. Students were directed to read the written instruction on each inventory very carefully and answer every question in the way that was most true of them. They were told that there was no right or wrong answer but that it was important to answer honestly. They were assured that no one will know their responses since their names were not on the tests. Students were asked to answer the items silently while sitting on their chairs but to raise their hands if faced any difficulty reading or understanding an item.

The respondents were asked to rate each item on a five-point likert scale ranging from 1 (“strong disagreement”) to 5 (“strong agreement”). Total
score was calculated by adding all the numbers rated from each answer. Higher score means a more positive attitude and a lower score means a more negative attitude towards foreign language learning. Positive attitude indicates less anxiety whereas negative attitude indicates more anxiety towards foreign language learning. The theoretical score range of this scale was from 33 to 165. For this study the score range was found 58 to 140. The higher the total anxiety scores were, the more anxious the student was.

Results

The results of the present study involved the computation of the coefficients of reliability and validity of FLCAS. Initially, Cronbach’s alpha was computed to determine the internal consistency reliability of the instrument. The results presented in Table-2 through Table-7. The reliability coefficients are quite comparable to those reported in the original instruments. Additionally, we computed corrected item-to-total correlations for each inventory to see how individual item goes with the total score.

Item analysis

The construct validity of a scale can be measured by assessing the correlation between individual item score and total test score. For the FLCAS, primarily the 33 items were thoroughly analyzed and corrected item-total correlation was determined. From the corrected item-total correlation value of 33 items were found to have significant item validity in the context of Bangladesh (see Table-2). Additionally, we computed 1\textsuperscript{st} Phase (Pre-testing I) and 2\textsuperscript{nd} Phase (Pre-testing II) corrected item-to-total correlations for each inventory to see how individual item goes with the total score (see Appendix Table-6 and Table-7).

Table -2: Item-Total Statistics and the Reliability of Final step of FLCAS in Field Test Sample (N=125)

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach's Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLCA1</td>
<td>101.2033</td>
<td>344.852</td>
<td>.320</td>
<td>.879</td>
</tr>
<tr>
<td>FLCA2</td>
<td>101.1138</td>
<td>342.118</td>
<td>.386</td>
<td>.878</td>
</tr>
<tr>
<td>FLCA3</td>
<td>101.2764</td>
<td>343.202</td>
<td>.363</td>
<td>.878</td>
</tr>
<tr>
<td>FLCA4</td>
<td>101.0407</td>
<td>346.875</td>
<td>.291</td>
<td>.880</td>
</tr>
<tr>
<td>FLCA5</td>
<td>101.4146</td>
<td>346.081</td>
<td>.315</td>
<td>.879</td>
</tr>
<tr>
<td>FLCA6</td>
<td>100.9756</td>
<td>348.663</td>
<td>.286</td>
<td>.879</td>
</tr>
<tr>
<td>FLCA7</td>
<td>101.7073</td>
<td>345.422</td>
<td>.320</td>
<td>.879</td>
</tr>
<tr>
<td>FLCA8</td>
<td>101.5447</td>
<td>337.955</td>
<td>.450</td>
<td>.876</td>
</tr>
</tbody>
</table>
Job Performance of the Medical Representatives in Relation to Big Five Personality Factors

### Note

Total scale α = .881.

### Cronbach alpha

In the Inventory of Foreign Language Classrooms Anxiety responses of four alternative sub scales are measured. So to measure the reliability of the scale Cronbach alpha method was used. The Cronbach alpha was found 0.881. This value is highly significant with an alpha level of 0.01 which indicates that the adapted form of the Inventory of Foreign Language Classrooms Anxiety is highly reliable. The Cronbach alpha among the subscales is given in the Table 3.

<table>
<thead>
<tr>
<th>Table 3: Reliability of the Sub-scale and Scale of Field Test Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>.881 (125)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub Scales</th>
<th>Communication Apprehension</th>
<th>Fear of Negative Evaluation</th>
<th>Test Anxiety Alpha (Items 5)</th>
<th>Anxiety of Foreign Language</th>
</tr>
</thead>
</table>
The results of the present study involved the computation of the coefficients of reliability and validity of each instrument. Initially, we calculated Cronbach’s alpha to determine the internal consistency reliability of the instruments. The results in Table 3 show reliability separately for the Sub-scale and Scale. The reliability coefficients are quite comparable to those reported in the original instruments.

To examine whether scores of inventories are stable over time, we administered them twice on a total of 18 students with an interval of 12 days. The interval was so chosen as to minimize the possibility of large fluctuations in the Foreign Language Classroom Anxiety of the student between two administrations (see Table 4). Research suggests that test-retest interval for measures used with student should be shorter (e.g., 1 week) if characteristics being measured (such as Anxiety) fluctuate substantially over time due to rapid developmental changes (Mitchell, Crosby, Wonderlich, and Adson, 2000; McCauley, 2001).

We computed coefficients of correlations between the two sets of data for each inventory to see the temporal stability of the test scores. Additionally, we computed t statistic to see the changes of scores over time. The Table 4 shows that all the instrument are highly reliable as evidenced by the coefficients of correlations. It also indicates that the adapted version is comparable to the original version in terms of its temporal stability. The

<table>
<thead>
<tr>
<th>FLCA</th>
<th>First Testing</th>
<th>Second Testing</th>
<th>Paired sample t test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Communication Apprehension</td>
<td>24.87</td>
<td>5.15</td>
<td>24.34</td>
</tr>
<tr>
<td>Fear of Negative Evaluation</td>
<td>30.01</td>
<td>6.17</td>
<td>29.21</td>
</tr>
<tr>
<td>Test Anxiety</td>
<td>12.96</td>
<td>3.42</td>
<td>12.44</td>
</tr>
<tr>
<td>Anxiety of Foreign Language Classes</td>
<td>37.26</td>
<td>7.16</td>
<td>35.00</td>
</tr>
</tbody>
</table>

Note: p < .05.

<table>
<thead>
<tr>
<th>FLCA</th>
<th>First Testing</th>
<th>Second Testing</th>
<th>Paired sample t test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Communication Apprehension</td>
<td>24.87</td>
<td>5.15</td>
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</tr>
<tr>
<td>Fear of Negative Evaluation</td>
<td>30.01</td>
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<td>29.21</td>
</tr>
<tr>
<td>Test Anxiety</td>
<td>12.96</td>
<td>3.42</td>
<td>12.44</td>
</tr>
<tr>
<td>Anxiety of Foreign Language Classes</td>
<td>37.26</td>
<td>7.16</td>
<td>35.00</td>
</tr>
</tbody>
</table>

Note: p < .05.
table also shows that anxiety scores attenuated significantly at the second time administration.

Correlation among the subscale:
Reliability refers to the degree to which measurements can be repeated that’s why it can be assumed that the scores of each subscale will be significantly correlated with each other. The Inventory of Foreign Language Classrooms Anxiety has four subscales.

Table-5: Correlations among the Subscales of the FLCAS for the Field Test Sample (N=125)

<table>
<thead>
<tr>
<th>Variable</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Communication Apprehension</td>
<td></td>
<td>.570** (125)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Fear of Negative Evaluation</td>
<td></td>
<td></td>
<td>.659** (125)</td>
<td></td>
</tr>
<tr>
<td>3 Test Anxiety</td>
<td>.439** (125)</td>
<td></td>
<td>.724** (125)</td>
<td>.657** (125)</td>
</tr>
<tr>
<td>4 Anxiety of Foreign Language Classes</td>
<td>.504** (125)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Numbers in Parentheses represent sample sizes. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

To assess validity of the instruments, we determined inter-correlations among the subscale of FLCAS. These provided evidences for the internal structure of the instrument. Overall, inventory scores were significantly correlated with each other within the field test group. Among the inventories, correlations between the Fear of Negative Evaluation, Test Anxiety and Anxiety of Foreign Language Classes were the highest ranging from .439 to .724 for the whole sample, (see Tables 5). A notably high correlation was observed between scores on the Fear of Negative Evaluation and Anxiety of Foreign Language Classes among the whole sample (r = .724). Correlations between scores on the Communication Apprehension and the other inventories were significant for the whole sample, (see Tables 5). These again were comparable to those for the original version of the instruments.

The Validity of the inventory of the Inventory of Foreign Language Classrooms Anxiety Scale (FLCAS)

Validity refers to the strength of the scale of measuring the Foreign Language Classrooms Anxiety or that aspect of anxiety for which it was intended to measure. In the cause of the inventory of Foreign Language Classrooms Anxiety Scale (FLCAS), validity refers to the strength of the scale of measuring Foreign Language Classrooms Anxiety Scale (FLCAS).
Different methods are used to measure the validity of a scale, among these, analyzing the content of test, investigating the particular psychological characteristics or constructs measured by the test are important. The validity of the Bangla version of the FLCAS was measured by using the following methods.

Content Validity

Content Validity refers to the systematic examination of the test content to determine whether it covers a representative sample of the behavior domains to be measured. Content validity of a test should be built during its construction. To assure the content validity of a scale, items of the scale must be selected and analyzed carefully during its construction. When the bangla version of the scale was given to the Subject Matter Experts (SMEs) it was found that the translated items are related about the insight of Foreign Language Classrooms Anxiety (FLCA). The Subject Matter Experts gave their essential remarks during the translation of the adapted version of the Scale.

Construct Validity

Construct validity refers to the extent to which the test measures a theoretical construct or trait. Item analysis method was used to determine the construct validity of the scale. When all the items measure the same construct then it is assumed that each item score will be significantly correlated with the total score of the scale. On the basis of this assumption these types of construct validity was determined. In the same way, when the sub scales of a particular scale measure the same construct then each subscale total will be significantly correlated with the total score of the scale.

Discussion

The present study was an extensive research work on the Scale of Foreign Language Classroom Anxiety. It was aimed at validation of the Foreign Language Classroom Anxiety Scale (FLCAS) into Bangla. Developing a new scale is highly complicated and time consuming, that is why the original FLCAS, which is already reliable and valid, was selected to validate in Bangla. The purpose of the present study was to adapt the widely used Foreign Language Classroom Anxiety Scale (FLCAS) for the use of language and cultural group of Bangladesh. Widely accepted adaptation process as recommended in the literature (e.g., Geisinger, 1994;
Hambleton, 2005; Hambleton & Patsula, 1999) was followed during the validation of the Bangla version of FLCAS. The results of the assessment of internal consistency and corrected item-total correlation indicated that the instrument is reliable and all items of the inventory are important or in other words non-redundant. The inter-correlations among three dimensions of the Bangla FLCAS are indicative of high convergent validity. Thus, the findings can be taken to suggest that the Bangla Foreign Language Classroom Anxiety Scale is suitable for assessing three main types of foreign language anxiety states of students in Bangladesh.

The present study demonstrated that the internal consistency reliability of all inventories of the Bangla FLCAS appeared acceptable or good as the Cronbach’s alpha ranged between .871 and .881. The criteria for evaluating alpha coefficient were derived from George and Mallery (2003) who provided the following rules of thumb: “α ≥ .9 – Excellent, .9 > α ≥ .8 – Good, 8 > α ≥ .7 – Acceptable, .7 > α ≥ .6 – Questionable, .6 > α ≥ .5 – Poor, and .5 > α – Unacceptable” (p. 231). It is noteworthy that the coefficients of alpha of the original FLCAS ranged from .83 to .91 considering all age band together which is slightly higher than those of the Bangla FLCAS. On the basis of the respondent’s responses the reliability and validity of the FLCAS were determined. In the process of determination of the reliability of the adapted version of the FLCAS, it was found that the Cronbach alpha is 0.893; Communication Apprehension is 0.678, Fear of Negative Evaluation is 0.676, Test Anxiety is 0.746 and the correlations among the subscales ranged from 0.504 to 0.656. These findings indicate that the validated version of the FLCAS possesses a high level of reliability which also ensures the usability of this scale in Bangladesh.

The studies on Foreign Language Classrooms Anxiety (FLCA) are necessary for understanding the underlying patterns of individual anxiety issues. More research is still required in this field to discover the relationship with other factors. Some limitations like economical, time, and manpower hindered the study in different ways. Future researchers should incorporate the relationship studies of Foreign Language Classrooms Anxiety (FLCA) with different variables or situations. Moreover this research will help future researchers to be inspired researching on this field.

References
Job Performance of the Medical Representatives in Relation to Big Five Personality Factors


Appendix

Table-6: Item-Total Statistics of 1st step of FLCAS (N =55)

<table>
<thead>
<tr>
<th>Items</th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach's Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLCA1</td>
<td>100.2545</td>
<td>353.267</td>
<td>.356</td>
<td>.879</td>
</tr>
<tr>
<td>FLCA2</td>
<td>100.0182</td>
<td>352.648</td>
<td>.375</td>
<td>.878</td>
</tr>
<tr>
<td>FLCA3</td>
<td>100.2545</td>
<td>352.119</td>
<td>.371</td>
<td>.878</td>
</tr>
<tr>
<td>FLCA4</td>
<td>99.9455</td>
<td>356.682</td>
<td>.238</td>
<td>.880</td>
</tr>
<tr>
<td>FLCA5</td>
<td>100.4909</td>
<td>358.032</td>
<td>.242</td>
<td>.880</td>
</tr>
</tbody>
</table>
### Table 7: Item-Total Statistics of 2nd step of FLCAS (N = 80)

<table>
<thead>
<tr>
<th>Items</th>
<th>Scale Mean if Item Deleted</th>
<th>Scale Variance if Item Deleted</th>
<th>Corrected Item-Total Correlation</th>
<th>Cronbach's Alpha if Item Deleted</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLCA1</td>
<td>101.7595</td>
<td>322.929</td>
<td>.295</td>
<td>.874</td>
</tr>
<tr>
<td>FLCA2</td>
<td>101.6962</td>
<td>318.496</td>
<td>.389</td>
<td>.872</td>
</tr>
<tr>
<td>FLCA3</td>
<td>101.8987</td>
<td>319.220</td>
<td>.381</td>
<td>.872</td>
</tr>
<tr>
<td>FLCA4</td>
<td>101.6203</td>
<td>322.828</td>
<td>.309</td>
<td>.874</td>
</tr>
<tr>
<td>FLCA5</td>
<td>101.9873</td>
<td>322.013</td>
<td>.322</td>
<td>.874</td>
</tr>
<tr>
<td>FLCA6</td>
<td>101.6076</td>
<td>326.421</td>
<td>.296</td>
<td>.875</td>
</tr>
</tbody>
</table>
### Foreign Language Classroom Anxiety Scale

1. I never feel quite sure of myself when I am speaking in my foreign language class.
   - Strong agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree

2. I don’t worry about mistakes in language class.
   - Strong agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree

3. I tremble when I know that I’m going to be called on language class.
   - Strong agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree

4. It frightens me when I don’t understand what the teacher is saying in the Foreign Language.
   - Strong agree
   - Agree
   - Neither agree nor disagree
   - Disagree
   - Strongly disagree

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<table>
<thead>
<tr>
<th>FLCA7</th>
<th>FLCA8</th>
<th>FLCA9</th>
<th>FLCA10</th>
<th>FLCA11</th>
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<th>FLCA24</th>
<th>FLCA25</th>
<th>FLCA26</th>
<th>FLCA27</th>
<th>FLCA28</th>
<th>FLCA29</th>
<th>FLCA30</th>
<th>FLCA31</th>
<th>FLCA32</th>
<th>FLCA33</th>
</tr>
</thead>
</table>

### Note:
Total scale $\alpha = .875$
5. It wouldn’t bother me at all to take more foreign language class
   Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
6. During language language class, I find myself thinking about things that have nothing to do with the course.
   Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
7. I keep thinking that the other students are better at language than I am.
   Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
8. I am usually at ease during tests in my language class.
   Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
9. I start to panic when I have to speak without preparation in language class.
   Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
10. I worry about the consequences of failing my foreign language class.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
11. I don’t understand why some people get so upset over foreign language class.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
12. In language class, I can get so nervous I forget things I know.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
13. It embarrasses me to volunteer answers in my language class.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
14. I would not be nervous speaking the foreign language with native speakers.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
15. I get upset when I don’t understand what the teacher is correcting.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
16. Even if I am well prepared for language class, I feel anxious about it.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
17. I often feel like not going to my language class.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
18. I feel confident when I speak in foreign language class.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
19. I am afraid that my language teacher is ready to correct every mistake
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
20. I can feel my heart pounding when I’m going to be called on in language class.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
21. The more I study for a language test, the more can-fused I get.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
22. I don’t feel pressure to prepare very well for language class.
    Strong agree Agree Neither agree nor disagree Disagree Strongly disagree
23. I always feel that the other students speak the foreign language better than I do.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
24. I feel very self-conscious about speaking the foreign language in front of other students.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
25. Language class moves so quickly I worry about getting left behind.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
26. I feel more tense and nervous in my language class than in my other classes.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
27. I get nervous and confused when I am speaking in my language class.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
28. When I'm on my way to language class, I feel very sure and relaxed.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
29. I get nervous when I don't understand every word the language teacher says.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
30. I feel overwhelmed by the number of rules you have to learn to speak a foreign language.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
31. I am afraid that the other students will laugh at me when I speak the foreign language.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
32. I would probably feel comfortable around native speakers of the foreign language.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
33. I get nervous when the language teacher asks questions which I haven't prepared in advance.
   Strong agree  Agree  Neither agree  nor disagree  Disagree  Strongly disagree
ব্যক্তিগত তথ্য

বয়স ৪

লিঙ্গ ৪ ১. ছেলে ২. মেয়ে [ টিক (✓) চিহ্ন দিন ]

আর্থ-সামাজিক অবস্থা ৪

মাধ্যম (বর্তমান ভাষা ) ৪ ১. ইংরেজি ২. কোরিয়ান ৩. জার্মান ৪. চীনা [ টিক (✓) চিহ্ন দিন ]

নির্দেশনা :
অনুযায় করে নিচের বিবৃতিসমূহ পড়ুন। কতগুলো বক্তব্য দেয়া আছে। প্রত্যেকটি বক্তব্যের ৫টি উত্তর দেয়া থাকবে, আপনাকে সেখান থেকে যে কোন একটি নির্বাচন করতে হবে- মেটি আপনার জন্য প্রযোজ্য।

আপনার দেওয়া তথ্যগুলো গোপন রাখা হবে এবং সেগুলো গুরুত্বপূর্ণ গবেষণার কাজে ব্যবহার করা হবে। আপনার সহযোগিতার জন্য ধন্যবাদ।

<table>
<thead>
<tr>
<th>নং</th>
<th>পদ / বিবৃতি সমূহ</th>
<th>সম্পূর্ণ</th>
<th>একমাত্র</th>
<th>কন্টাইন</th>
<th>ভিত্তিত</th>
<th>সম্পূর্ণ</th>
<th>ভিত্তিত</th>
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</thead>
<tbody>
<tr>
<td>১</td>
<td>বিদেশী ভাষার ক্লাসে কথা বলার সময় আমি কখনই নিজেকে আলোচনায় মনে করি না।</td>
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<td>২</td>
<td>ভাষা শিক্ষার ক্লাসে ভুল করা নিয়ে আমি উদ্দিষ্ট হই না।</td>
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<td>৩</td>
<td>আমি যখন জানতে পারি এই ভাষার ক্লাসে আমাকে ডাকা হচ্ছে তখন আমি কাপড়ে থাকি।</td>
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<td>৪</td>
<td>শিক্ষক বিদেশী ভাষায় কি বলবে তা না বুঝতে পারলে আমি আত্মসমৃদ্ধি বোধ করি।</td>
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<td>৫</td>
<td>বিদেশী ভাষার ক্লাস আরো বেশী নিলেও আমি বিরত হই না।</td>
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<td>৬</td>
<td>ভাষার ক্লাসের সময় সেবক বিষয়ে আমি চিন্তা করি সেবক আমার বিষয় সংশ-ই নয়।</td>
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<td>৭</td>
<td>আমি ভাবি যে অন্যান্য ছাত্রছাত্রীরা ভাষার ক্ষেত্রে আমার দেয়া পড়ে।</td>
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<td>৮</td>
<td>আমি সাধারণত ভাষার ক্লাসের পরীক্ষায় সাদা ভোগ করি।</td>
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<td>৯</td>
<td>কোন প্রশ্ন ছাড়া ভাষার ক্লাসে কথা বলতে হলে আমি আত্মসমৃদ্ধি বোধ করি।</td>
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<tr>
<td>নম্বরঃ</td>
<td>বিদেশী ভাষার ক্লাসে ব্যবহৃত ভাষা পরিপঠন সময়ে আমি উদ্ধৃতি থাকি।</td>
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<td>১০</td>
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</tbody>
</table>

| নম্বরঃ | আমি বুঝতে পারি না কেন যে কিছু লোক বিদেশী ভাষার ক্লাসে এত বেশী ঘাবড়ে যায়। |
| ১১  | |

| নম্বরঃ | ভাষার ক্লাসে আমি একটাই ঘাবড়ে যাই যে জন্য বিষয়গুলো আমি ভুলে যাই। |
| ১২  | |

| নম্বরঃ | ভাষার ক্লাসে বেহুলা উত্তর দিতে বিবর্তন বোধ করি। |
| ১৩  | |

| নম্বরঃ | আমি বিদেশী মাতৃভাষাভাষীদের সাথে কথা বলতে ঘাবড়ে যাব না। |
| ১৪  | |

| নম্বরঃ | শিক্ষক কর্তৃক সংশোধন করা কোন বিষয় যখন আমি বুঝতে পারি না তখন খুব বিপর্যস্ত হই। |
| ১৫  | |

| নম্বরঃ | ভাষার ক্লাসের জন্য ভাল ভাবে প্রস্তুতি নেয়া সত্ত্বেও আমি খুব উদ্ধৃতি হয়ে পড়ি। |
| ১৬  | |

| নম্বরঃ | আমি প্রায়শই ভাষার ক্লাসে না যাওয়ার কথা ভাবি। |
| ১৭  | |

| নম্বরঃ | বিদেশী ভাষার ক্লাসে কথা বলার সময় আমি নিজেকে আত্মবিশ্বাসী মনে করি। |
| ১৮  | |

| নম্বরঃ | আমার ভাষা শিক্ষক প্রত্যেকটি ভুল ধরিয়ে তা ঠিক করে দেবার জন্য সব সময় তৈরি থাকেন বিধায় আমি খুব ভাবে থাকি। |
| ১৯  | |

| নম্বরঃ | ভাষার ক্লাসে আমাকে ডাকলে আমার হৃদকম্পন শরম হয়। |
| ২০  | |

| নম্বরঃ | আমি ভাষার পরীক্ষার জন্য যত পড়াশুনা করি ততই তালগোল পাকাতে থাকি। |
| ২১  | |

| নম্বরঃ | ভাষার ক্লাসের জন্য ভালোভাবে প্রস্তুতি নিতে আমি কোন চাপ অনুভব করি না। |
| ২২  | |

<p>| নম্বরঃ | আমি সর্বদাই মনে করি অন্যান্য ছাত্রছাত্রীরা বিদেশী ভাষা আমার চেয়ে ভাল বলতে পারে। |
| ২৩  | |</p>
<table>
<thead>
<tr>
<th></th>
<th>Job Performance of the Medical Representatives in Relation to Big Five Personality Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>অন্যান্য ছাত্রছাত্রীদের সামনে বিদেশি ভাষায় কথা বলার সময় আমি বেশ আল্প-প্রভায় বোধ করি।</td>
</tr>
<tr>
<td>25</td>
<td>ভাষার ক্লাস এত দ্রুতগতির চলে যে আমি পিচিয়ে পড়ার ভয় করি।</td>
</tr>
<tr>
<td>26</td>
<td>অন্যান্য ক্লাসের চেয়ে ভাষার ক্লাসে আমি বেশি স্বায়ত্ব বোধ করি।</td>
</tr>
<tr>
<td>27</td>
<td>আমি যখন ভাষার ক্লাসে কথা বলি তখন খুব বেশি জীত এবং দ্বিপ্রপ্রস্তুতি।</td>
</tr>
<tr>
<td>28</td>
<td>ভাষার ক্লাস অতিভূত গমনরত অবস্থায় আমি নিষ্ঠেজ্জুড় ও প্রশান্ত বোধ করি।</td>
</tr>
<tr>
<td>29</td>
<td>ভাষা শিক্ষকের বক্তব্যের প্রতিটি শব্দ যখন আমি বুঝতে পারি না তখন খুব ঘোরড় যাই।</td>
</tr>
<tr>
<td>30</td>
<td>বিদেশি ভাষায় কথা বলার জন্য নিয়মকানুনের সংখ্যাবিশেষ আমি বেসামাল বোধ করি।</td>
</tr>
<tr>
<td>31</td>
<td>বিদেশি ভাষায় কথা বলার সময় অন্যান্য ছাত্রছাত্রীরা আমাকে নিয়ে উপহাস করবে এই ভেবে আমি খুব জীত হয়ে পড়ি।</td>
</tr>
<tr>
<td>32</td>
<td>আমি বিদেশী মাতৃভাষাভাষীদের চারপাশে স্বাভাবিক বোধ করব।</td>
</tr>
<tr>
<td>33</td>
<td>আমার প্রক্রিয়া নেই এমন বিষয়ে যখন ভাষা শিক্ষক আমাকে প্রশ্ন করেন তখন আমি ঘোরড় যাই।</td>
</tr>
</tbody>
</table>
Efficacy of Psychotherapeutic Interventions In Managing Psychological Problems of Women with Breast Cancer

Sabiha Jahan
Bangladesh-Kuwait Moitre Hall
Dhaka University
and
M. Anisur Rahman
Department of Clinical Psychology
Dhaka University

Abstract
The study was conducted to see the effect of psychotherapeutic interventions in managing psychological problems of women with breast cancer. Ten female patients with breast cancer were selected purposively with the help of General Health Questionnaire (GHQ-28) and pre determined inclusion and exclusion criteria. Single case study method was employed to explore psychological sufferings associated with breast and pre-post design was used to see the effect of psychotherapeutic interventions in managing psychological problems of the subjects. To collect data from the participants in-depth interview, Hospital Anxiety Depression Scale (HADS), general Health Questionnaire (GHQ-28), socio-demographic questionnaire and 11 point rating scale were used. Participants were asked to provide baseline rating of their problems, to fill in HADS, GHQ-28 and functional level assessment to collect quantitative baseline measures at the first session. After collecting baseline data and psychometric measures in-depth interview was used to explore the nature and intensity of psychological problems of the participants after being diagnosed of having breast cancer. Cognitive behavior therapy was applied and in the last session the researcher applied post measures using same quantitative measures administered in the first session. The findings of this study evince that breast cancer diagnosis and its treatment were associated with severe emotional distress, physical effects of breast cancer treatment and even after completing a successful treatment the participants of this study felt hopeless, sad and worried about recurrence. Significant improvement occurred regarding the participants’ cognitive, behavioral, emotional, physical and environmental problems.
Introduction

Cancer is a serious health problem both in developing and developed countries. Breast cancer is the second most common type of cancer worldwide while among women cancer patients 32% suffer from breast cancer and their mortality rate is 15% (American Cancer Society, 1996). Incidence rates of breast cancer are increasing in most countries. According to the draft annual report 2005 of the National Institute of Cancer Research and Hospital, Dhaka, top five cancers in females are cervix 24.6 per cent, breast 24.3 per cent, lungs 5.5 per cent, oral cavity 4.1 per cent and ovary 3.8 per cent (Annual report, 2005 of the National Institute of Cancer Research and Hospital, Dhaka).

A woman with breast cancer experiences a range of physical, psychological and practical challenges throughout the journey with breast cancer (National Breast Cancer Center and National Cancer Control Initiative, 2003). Several studies have reported that a diagnosis of breast cancer is an emotionally challenging disease for women (Stanton, Danoff-Burg, Cameron, Bishop, Collins, Kirk, Sworowski, & Twillman, 2000; Vickberg, Bovbjerg, DuHamel, Currie & Redd, 2000). And those women face emotional challenges in each phase of the breast cancer experience (Lyons, Jacobson, Prescott, & Oswalt, 2002; Taylor, 2000). Some factors are very much related for potential emotional distress to breast cancer among women include younger age at diagnosis (Compas, Stoll, Thomsen, Oppedisano, Epping-Jordan & Krag, 1999), uncertainty of illness and fear of disease recurrence (Mast, 1998), fear of rejection and sexuality concerns (Spencer, Lehman, Wynings, Arena, Carver, Antoni, Derhagopian, Ironson, & Love, 1999), side effects related to cancer treatment (Mock, Dow, Meares, Grimm, Dienemann, Haisfeld-Wolfe, Quitasol, Mitchell, Chakravarthy & Gage, 1997), and having a mastectomy (Harcourt, Rumsey, Ambler, Cawthorn, Reid, Maddox, Kenealy, Rainsbury, Umpleby, 2003).

Research data indicate that recovery from breast cancer is better if the patient receives emotional support during and after the initial stages of diagnosis and treatment. Psychotherapeutic interventions for persons with cancer and other chronic illnesses typically use cognitive behavior techniques, often incorporating skills training and relaxation training. The interventions typically focus on reducing general distress, and they appear effective (Andersen, 1992; Trijsburg, Knippenberg & Rijpma, 1992). Some study supports the use of both Cognitive Behavior therapy and Relaxation and Guided Imagery models to reduce psychological distress of breast cancer patients. Relaxation and Guided imagery showed advantages in
reducing fatigue and improving quality of sleep, whereas Cognitive Behavior therapy better reduced external health locus of control perceptions (Cohen and Georgeta, 2007).

Objectives of the present study

Objective: To observe the effect of psychotherapeutic interventions in managing psychological problems of women with breast cancer.

Specific Objectives:

1. To assess psychological problems among women with breast cancer.
2. To see the outcome of psychological management among women with breast cancer.

The investigation

The Participants

The participants of this study were 10 females with breast cancer attending the Oncology Department of two private hospitals. Age range of the participants was 25-57 years and their average age was 43.2. Participants were selected purposefully. Participants from all stages of breast cancer were included and those suffering from psychosis and any other physical illnesses were excluded.

Research Design

The present study was conducted using both qualitative and quantitative research method. Single case study was employed to explore psychological issues associated with breast cancer.

Measures and means of collecting data

The following methods were used to collect data from participants:

1. Socio-demographic questionnaire
2. In-depth interview
3. Hospital Anxiety depression Scale (HADS)
4. General Health Questionnaire (GHQ-28)
5. 11 point self-rating scale where 1 means no problem at all and 11 means highest problem.

Procedure
In the first phase ten female patients with breast cancer were selected purposively with the help of GHQ 28 and pre determined inclusion and exclusion criteria from Oncology Department, City hospital, Lalmatia and Quality Care Hospital, Dhaka. Each of the respondents was asked to complete socio demographic information according to socio demographic questionnaire prepared by the researcher and fill in GHQ-28. Each participant was asked at the first session to provide baseline rating of her problems, to fill in HADS, GHQ-28 and functional level of assessment to collect quantitative baseline measures. After collecting baseline data and psychometric measures the researcher (first autoor) used in-depth interview to explore the nature and intensity of specific psychological problems of the participants after being diagnosed of having breast cancer. This was followed by case conceptualization. After taking proper assessment formulation sharing treatment goal was set collaboratively. According to data collected from assessment session the researcher administered psychotherapy like cognitive behavior therapy, interpersonal therapy, marital therapy and family therapy. In the last session the researcher administered post measures using the same quantitative measures administered in the first session.

Data processing and analysis

Quantitative data from self rating of patient’s problems, functional level assessment rating and psychometric tools (GHQ-28 and HADS) were analyzed by graphical presentation. Qualitative data analysis was an on-going process that began as soon as the researcher started to provide session with clients and continued until preparing the final report.

Ethical considerations

Before administering the questionnaire, verbal consent was taken from potential respondents to participate in the study. The participants were assured of about confidentiality of the data collected from them.

Results and Discussion

The findings of this research are presented below according to the broad category of the research objectives along with concise case summary.
Table 1: shows problem categorized into five domains such as behavioral, affective, cognitive, physiological and social.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Pre- intervention session</th>
<th>Post- intervention session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral domain</td>
<td>Avoiding social interactions, (9 out of 10) Decreased activity level, (7 out of 10)</td>
<td>Increased activity level (10 out of 10)</td>
</tr>
<tr>
<td></td>
<td>All the day lying on bed, (7 out of 10)</td>
<td>Started to join social activities, (8 out of 10)</td>
</tr>
<tr>
<td></td>
<td>Crying, (4 out of 10)</td>
<td>Started to count pleasurable activity (10 out of 10)</td>
</tr>
<tr>
<td></td>
<td>Frequent visit to the doctors' chamber or Call doctor frequently (1 out of 10)</td>
<td>spend lots of time with family(5 out of 10)</td>
</tr>
<tr>
<td></td>
<td>Slowness in movement (2 out of 10)</td>
<td>Made positive and enjoyable conversation with husband (1 out of 1 )</td>
</tr>
<tr>
<td></td>
<td>Avoid personal relationship with husband (1 out of 10)</td>
<td></td>
</tr>
<tr>
<td>Affective domain</td>
<td>Depressed mood (7 out of 10) loss of pleasure(8 out of 10) helplessness (6 out of 10)</td>
<td>Able to find out pleasure in life(7 out of 10)</td>
</tr>
<tr>
<td></td>
<td>hopelessness (7 out of 10)</td>
<td>Able to be hopeful for future(7 out of 7)</td>
</tr>
<tr>
<td></td>
<td>feeling of guilt (3 out of 10)</td>
<td>Reduced symptoms (6 out of 10)</td>
</tr>
<tr>
<td></td>
<td>worry of recurrence (2 out of 10)</td>
<td>Reduce self blame and guilty (3 out of 3)</td>
</tr>
<tr>
<td></td>
<td>anger (3 out of 10)</td>
<td>Try to control anger and deal with assertively (2 out of 2)</td>
</tr>
<tr>
<td></td>
<td>irritability (3 out of 10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>low self esteem (low self esteem)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>fear of dying (1 out of 10)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>apathy (1 out of 10)</td>
<td></td>
</tr>
<tr>
<td>Cognitive domain</td>
<td>Concentration problem (7 out of 10) Indecisiveness (3 out of 10) Rumination about cancer related thoughts (4 out of 10) Suicidal ideation (1 out of 10)</td>
<td>Symptoms disappeared (7 out of 10)</td>
</tr>
<tr>
<td></td>
<td>Symptom reduced (3 out of 10)</td>
<td>Learned to make decision using pros and cons (3out of 3)</td>
</tr>
<tr>
<td>Social domain</td>
<td>Disrupted interpersonal relationship (8 out of 10)</td>
<td>Regain social interaction (8 out of 8)</td>
</tr>
<tr>
<td></td>
<td>Financial problems, (5 out of 10)</td>
<td>Develop adaptive coping strategies to deal with her stress (7 out of 10)</td>
</tr>
<tr>
<td></td>
<td>Stress about family (4 out of 10)</td>
<td>Made decision to overcome financial crisis (4 out of 5)</td>
</tr>
<tr>
<td></td>
<td>Stress about job (2 out of 10)</td>
<td>Able to share stress with family members (2 out of 4)</td>
</tr>
<tr>
<td></td>
<td>Family sickness(1 out of 10)</td>
<td>Make decision about her job and provide her substitute (2 out of 2)</td>
</tr>
<tr>
<td>Physiological domain</td>
<td>Decreased sleep; (10 out of 10)                          Loss of appetite, (8 out of 10)                        Fatigue, lethargic (7 out of 10)                        Headache, (3 out of 10)                        Lack of sexual desire (3 out of 10)                        Anemia, (1 out of 10)                        Chest pain (1 out of 10)</td>
<td>Reduced symptoms like sleep disturbance, fatigue and loss of appetite (6 out of 7)                        Symptoms disappeared (8 out of 10)                        For anemia patient sought information from doctor and tried to follow suggestion</td>
</tr>
</tbody>
</table>
Job Performance of the Medical Representatives in Relation to Big Five Personality Factors

| Tremor (1 out of 10) | Heart burning (1 out of 10) |

It can be seen that there are differences in behavioral, affective, cognitive, social and physiological domains in the pre intervention, post intervention sessions.

**Figure-1**: Subjective rating by client

Figure-1 presents graphical representation of improvement of self rating of ten patients.

**Figure-2**: GHQ 28 score of pre, post and follow up session where above 39 score indicates clinically distressed
Figure-2 presents graphical representation of improvement of GHQ score.

![Graphical representation of improvement of GHQ score]

Figure-3: HADS depression score

Figure-3 presents graphical representation of improvement of HADS depression score.

![Graphical representation of improvement of HADS depression score]

Figure-4: HADS anxiety score

Figure-4 presents graphical representation of improvement of HADS Anxiety score.

The findings of this study suggest that women with breast cancer frequently experience psychological distress owing to their illness and its treatment. Breast cancer related psychological problems can range from feelings of sadness and worry to more disabling emotional problems such as depression and anxiety. According to the data obtained in case studies show that the participants of this study also experienced a bunch of...
psychological problem which can be categorized into five major domains. These domains were cognitive problems, behavioral problems, affective problems, physiological problems related to breast cancer and its treatment, and socio-economic problems. At different phases of breast cancer starting from diagnosis itself and through different physical treatments the respondents experienced psychological distress. Diagnosis of breast cancer was perceived as a traumatic event by the participants of this study. In addition to this they had to go through various types of medical examinations, choose treatment option like surgery or chemotherapy and lastly had to go through the painful physical treatments along with numerous short and long term side effects. This finding replicates the findings of Kornblith and Ligibel (2003). They found specific signs and symptoms of distress in breast cancer women including concerns about illness and decline in health, anger, sleep difficulties, poor appetite, concentration difficulties and preoccupation with thoughts of illness and death. Glanz and Lerman (1992) found that as many as a quarter of women with breast cancer suffered from clinically significant psychological problems. Regarding cognitive problems the participants reported to have some negative automatic thoughts like “I can’t cope with cancer”, “I will die”, “I am worthless” etc and some cognitive problems like loss of memory, concentration problem, indecisiveness, rumination about cancer related thoughts and suicidal ideation.

Several studies have successfully used relaxation and imagery techniques to treat distress in breast cancer women at various stages of illness (Kristin and Montgomery, 2006; Hidderley & Holt, 2004; Molassiotis et al., 2002; Montgomery, G. H., Weltz, C. R., Seltz, M., and Bovbjerg, D. H., 2002; Williams and Schreier, 2004). A telephone treatment using cognitive therapy components found improvements in distress in a group of newly diagnosed breast cancer patients (Sandgren, McCaul, King, O’Donnell, & Foreman, 2000).

In the present study it was also found that almost all had decreased activity level and lack of social interaction as behavioral problem along with breast cancer. Some patients were crying during session and some anxious patients reported that they frequently visited doctor’s chamber to assess their current health status. These findings were corroborated by some other researches which found that after diagnosis of breast cancer women feel hopeless, depressed and lose interest in all activities (Servaes et al, 2003; Young & White, 2006).
As diagnosis of breast cancer is a traumatic experience, women usually face a lot of emotional reactions to cope with this shocking event. Not only diagnosis, breast cancer treatment and sometimes following successful treatment women often experience negative emotions. The findings of the current study also showed that women with breast cancer face negative emotions like depression, loss of pleasure, hopelessness, and helplessness. Results of the present study also revealed that women experience feelings of guilt, self blame, fear of recurrence, fear of dying, and worry about health. In addition to these, some patients mentioned to have excessive anger and irritation. Women with breast cancer have to proceed on different types of screening, have to choose a treatment option according to their nature and severity of breast tumor and finally have to run through relatively long and fearful treatment methods like chemotherapy, radiotherapy or even breast surgery with enormous side effects like loss of hair and nail, nausea, fatigue and so on (Servaes et al., 2002; Prue et al., 2006). So, they become depressed and they gradually lose their normal behavioral pattern (Young & White, 2006; Servaes et al., 2002; Prue et al., 2006). Numerous studies have also documented that diagnosis of breast cancer is an emotionally challenging disease for women (Koopman et al., 2001; Stanton et al., 2000; Vickberg et al., 2000). Women face emotional challenges in each phase of the breast cancer experience (Taylor, 2000).

All patients had sleep difficulties in course of breast cancer diagnosis, treatment or even after treatment Other than sleep difficulties women also experienced loss of appetite, fatigue, loss of hair, nausea and headache. Some patients reported to experienced loss of sexual interest due to breast cancer treatment. Sexual problems may directly originate from the side effects of adjunct therapies, especially chemotherapy and hormonal therapy (Anllo, 2000).

Women with breast cancer had some other psychological problems categorized as environmental problems like disrupted interpersonal relationship, financial crisis, and stress about family and job. This is the first study on the effect of psychotherapeutic interventions in managing psychological problems of women with breast cancer in Bangladesh. So, the major findings of the present study add to an expanding body of evidence of the effectiveness of psychotherapeutic interventions especially cognitive behavior therapy for women with breast cancer.
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Childhood Abuse and Current Psychological Problems of University Female Students

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Abstract
The present study observed different psychological problems of a sample of female students living in a residential hall of a university. Specifically, the objective was to find out the occurrence of different types of psychological problems stemming from childhood abuse experienced and reported by the female clients seeking psychological services in the counseling centre of a residential hall of this university. The sample consisted of 30 students of which 22 reported having experienced childhood abuse. Their age ranged from 21 to 25 years and they were studying in different Departments. In-depth interview about childhood experiences formed the major method of collecting data. The findings revealed that they had experienced different kinds of abuse in their childhood such as, physical abuse, emotional abuse, sexual abuse, neglect, and overprotection. According to these data collected through in-depth interview, emotional abuse (77.27%) and neglect (77.27%) topped the list. Next in order were sexual abuse (45.45%), physical abuse (36.36%), and overprotection (36.36%). In order to assess their consequences some psychological tests viz., Anxiety Scale, Depression Scale, Social Anxiety Inventory, Maudsley Obsessive-Compulsive Inventory and symptom analysis according to DSM IV, were used on the sample. These data indicated that anxiety and depression were the most frequent consequences. Sleep disorder, poor academic performance, suicidal thought and attempt and self-harm were among other effects observed among these female clients experiencing childhood abuse.

Introduction
Childhood abuse is a huge global problem but we know little about it. So far what we know represents only the “tip of the iceberg” of the real phenomenon, where only a small proportion would be seen “above the surface” (WHO, 2004). There is incomplete and inconsistent information on the prevalence of maltreatment, its socio-demographic risk factors, and its relationship to future health. (Hussey, Chang, and Kotch, 2006). Recently, the World Health Organization (WHO) estimated that about 40 millions
children aged 0-14 years around the world suffer from abuse and neglect that require health and social care (WHO, 2006).

Bangladesh is an over populated country and child abuse in different forms like physical, emotional sexual etc are common. Children are being abused both inside and outside the house either by authoritarian rules or by over permissive, overprotective and neglecting parenting. Consequences of those abuses may contribute to the development of cognitive distortions and different forms of psychopathology especially depression (Hossain & Begum, 2009). Different theories also suggest that painful negative experiences in childhood may contribute to the development of psychopathology in later life (Beck, 1967; Bowlby, 1973, 1980). Relationship between history of physical or sexual abuse and diagnosis of depression and anxiety in adulthood is evident in some studies (Paolucci et al., 2001; Putnam, 2003; Rodriguez et al., 1998). Some literature also shows that childhood emotional abuse and adulthood depression are linked (Bifulco et al., 2002; Gibb et al., 2001, 2003). In addition, there is some evidence for relation between a history of childhood emotional abuse and the presence of anxiety disorders, particularly social phobia in adulthood (Harkness and Wildes, 2002; McCabe et al., 2003). Experiencing a traumatic event like physical, sexual, emotional abuse and so on can have serious impact on a student’s mental health as well as his or her overall wellbeing and ability to succeed in the college/university environment. A study reveals that about 31% of students seeking services from college counseling centers reported having experienced a traumatic event either before or since coming to college (Ben Locke, 2009).

Though the literature shows that the evidence of relationship between childhood abuse and psychopathology in adulthood is increasing, in Bangladesh we do not have comprehensive study on this issue. Poverty, insufficient knowledge of parenting etc are very common among the mass population of Bangladesh and these factors increase the vulnerability of childhood abuse. As childhood abuse may have adverse effect in adult mental health and mental health problems contribute to develop disability in everyday life that ultimately acts as a negative factor of national development, understanding these issues are very important in Bangladesh context.
Young generation is the source of energy for a country and university students are most important among them. The mental health of today’s university students has impact on the educational environment, including an individual student’s ability to cope with stress, class curricula, residence life, students activities, and critical incidents—all of which influence the entire college or university community. Therefore the following objectives were set for the current study.

- To understand the experiences of childhood abuse among female students who had different forms of psychological problems.
- To know the pattern of psychological problems predisposed by childhood abuse.

Methodology

Sample

The sample of the study comprised 30 female students of a university, who were the residents of a hall and received psychological services for different types of psychological problems. These 30 students were randomly selected by lottery from 150 service receivers. Average age of the sample was 23.3 years ranging from 21 to 25 years. Academic qualification of the students varies from 1st year Honours to master’s level. Socioeconomic status varies from lower to middle class but most of the respondent had financial insecurity due to irregular financial support from family.

Instruments

In-depth clinical interview and symptom checklist of DSM-IV were the basic instrument used in this study. Moreover, the following scales were also used along with clinical assessment. Anxiety Scale (Deeba & Begum, 2004), Depression Scale (Uddin & Rahman, 2005), The Social Phobia and Anxiety Inventory (Samuel, Deborah, Constance and Melinda, 1989), Bangla translated version (Mozumder, 2005) of Maudsley Obsessive-Compulsive Inventory (Hodgson and Rachman, 1977) and were used as the instrument for the current study.

Design

Exploratory case study design was used where all cases were assessed to explore childhood abuse and current psychological problems for
understanding the relationship between childhood abuse and current psychological problems.

Procedure

A total of 150 female students were selected among a number of female students suffering from and getting treatment for psychological problems. Students who had given their consent and who were suffering from different types of psychological problems except psychosis were drawn for this study. As the present study objectives were perused qualitatively and it was not possible to manage huge data set of large sample, 30 respondents were randomly drawn by lottery. All cases were assessed by in-depth clinical interview and relevant psychometric scales having good psychometric properties and norms. The scales were used to assist clinical assessment by which complete assessment, case conceptualization and formulation were done. Verbal consent for using the clinical data in conducting research by maintaining confidentiality had been taken. Any information focusing personal identification was avoided to ensure the maintenance of confidentiality. All data were collected by the first author and analyzed by both researchers who were conscious enough to control their subjective bias by using bracketing (Tufford and Newman, 2012) to ensure the validity.

Data Analysis

According to the principle of qualitative data analysis it was started along with data collection. As the interviewer herself was an experienced clinical psychologist, she guided the assessment based on the data given by the respondent and her clinical judgment along with psychometric assessment. Finally the written transcripts of sessions, for each sample were thoroughly read again and again due to coding the data according to research objectives. By content analysis all coded data were categorized and were presented using descriptive statistics like Tables and figures.

Results and Discussion
The above figure indicates that among the total (30) sample most of them (73.33%) had positive history of different forms of abuse and 26.67% did not have any history of abuse but all of them had different types of psychological problems.

### Table 1: Types and percentage of Exposure to different forms of Childhood Abuse reported by the sample

<table>
<thead>
<tr>
<th>Types of abuse</th>
<th>Total -30</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>8 out of 22</td>
<td>36.36</td>
</tr>
<tr>
<td>(Slapped, hit with object, shacked, pushed or kicked)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>17 out of 22</td>
<td>77.27</td>
</tr>
<tr>
<td>(Insulted, criticized, scolded or bad language, blackmail, tight rules, rejection, threatened, emotional punishment for minor fault)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>10 out of 22</td>
<td>45.4</td>
</tr>
<tr>
<td>Fondled by abuser, forced to view abuser private part, forced to view and touch abuser’s private parts, forced for contact sexual assault, photographed in the nude, raped.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect</td>
<td>17 out of 22</td>
<td>77.27</td>
</tr>
<tr>
<td>Deprivation from physical needs for feeding, clothing and shelter, deprived from love and affection, deprivation from safety needs for protection, deprivation from emotional needs for nurturance and secure base, lack of positive reinforcement for positive behavior/ work.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table-2: Offenders of different types of child hood abuse reported by female university student

<table>
<thead>
<tr>
<th>Type of abuse</th>
<th>Reported Offender (relation with student)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td>Parent, sibling, cousin, grand parent.</td>
</tr>
<tr>
<td>Emotional abuse</td>
<td>Parent, adopted parent, sibling, cousin, grand parent, step parent, step sibling, other relatives</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>Private teacher, extra family friends, relatives, Neighbor, boy friend</td>
</tr>
<tr>
<td>Neglect</td>
<td>Parent, step parent, grand parent and other relatives.</td>
</tr>
<tr>
<td>Over protection</td>
<td>Parent</td>
</tr>
</tbody>
</table>

Table-3: Family condition regarding parents

<table>
<thead>
<tr>
<th>Family condition regarding Parent</th>
<th>Number of student (Total 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One parent psychiatric patient</td>
<td>3</td>
</tr>
<tr>
<td>Both parents psychiatric patient</td>
<td>2</td>
</tr>
<tr>
<td>Father drug abuser</td>
<td>2</td>
</tr>
<tr>
<td>Step parent</td>
<td>2</td>
</tr>
<tr>
<td>Disturbed parent relation/ family environment</td>
<td>3</td>
</tr>
<tr>
<td>parents separated/ divorced</td>
<td>2</td>
</tr>
<tr>
<td>Adopted parent</td>
<td>1</td>
</tr>
<tr>
<td>Poor economic condition</td>
<td>13</td>
</tr>
</tbody>
</table>

Findings of Table -1 indicates that emotional abuse and neglect was in highest percentage (77.27) and sexual abuse was reported as the second highest percentage (45.45). It also shows that parents were the common perpetrator in all forms of abuse except sexual abuse. Moreover, Emotional abuse and neglect were used by most of the family members from whom we usually expect most of emotional and esteem support, affection, love as well as instrumental supports. As the most important sources of support were negative for the respondents, most of the participants experienced emotional abuse and neglect. Moreover Table-3 shows that family...
condition of most of the respondents was not favorable for positive mental health that might have increased the vulnerability for being abused either emotionally or physically and so on.

![Bar graph showing psychological problems according to different abuse]

**Figure-2:** Bar of Psychological problems according to different abuse

**Table-4:** Frequency and percentage of different types of psychological / emotional problem experiencing different types of childhood abuse

<table>
<thead>
<tr>
<th>Psychological Problems</th>
<th>Number and percentage of client according to pattern of abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical</td>
</tr>
<tr>
<td>Anxiety</td>
<td>8 (36.36%)</td>
</tr>
<tr>
<td>Depression</td>
<td>4 (18.18%)</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>3 (13.63%)</td>
</tr>
<tr>
<td>Hostility (anger/frustration)</td>
<td>2 (9.09%)</td>
</tr>
<tr>
<td>Social Anxiety</td>
<td>1 (4.54%)</td>
</tr>
<tr>
<td>OCD</td>
<td>1 (4.54%)</td>
</tr>
<tr>
<td>Poor academic performance</td>
<td>7 (31.81%)</td>
</tr>
<tr>
<td>Adjustment problem</td>
<td>1 (4.54%)</td>
</tr>
<tr>
<td>Relationship problem</td>
<td>1 (4.54%)</td>
</tr>
<tr>
<td>GAD</td>
<td>1 (4.54%)</td>
</tr>
<tr>
<td>Suicidal thought/ideation/attempt</td>
<td>0</td>
</tr>
<tr>
<td>Self harm</td>
<td>0</td>
</tr>
<tr>
<td>Somatic problem</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure-2 and Table-4 indicate that participants having emotional abuse and neglect had higher rates and number of psychological problems. According to the current findings (table-2), as emotional abuse and neglect were experienced by family members that were unexpected in Bangladesh culture. In Bangladesh culture people usually seek all types of support from parents and family member. But as the respondent could not expect and get satisfaction regarding their different need from their parents so they felt neglected and valueless. Feeling neglected and valueless regarding early life experiences leads to develop maladaptive cognitive schema towards self, cognitive distortion and other dysfunctional beliefs (Hossain & Begum, 2009). Developing those types of cognitive construct make people more vulnerable for suffering from psychopathology. Moreover, emotional abuse and neglect might negatively influence to build positive attachment with their parents. As a result those children might be more vulnerable and have experience of other form of abuse as well. As for example when a child does not get attention, affection and warmth from the parents and family members they try to seek from other people like neighbors, relatives, boy friends, house tutors etc and it was observed in the current study that most of the sexual abuse was offended by those people. Figure-2 also shows that anxiety were the most common psychological problems among all types of abuse victim. The reason behind this findings is that all the respondents were female and they had a fear of re-experiencing of those abuse due to socioeconomic vulnerability of women in Bangladesh. Therefore, possibly they had a rumination of their painful experiences as well as had negative schema due to those experiences. Due to critical incidence of their life the negative beliefs, schema etc were activated. As their cognitive schema were focused on fear so their most reported problem was found as anxiety.

Clients having experience of sexual abuse had higher rates of depression, anxiety and self-harm problems but they had comparatively less problems than emotional abuse and neglect. Literature reveals that adults having experience of childhood sexual abuse report increased rates of depressive symptoms (Bagley, Wood & Young, 1994., Silverman, Reinherz & Giaconia, 1996), increased rates of anxiety disorder (Briere & Runtz,1988; Fergusson et al., 1996), increased rates of suicidal and self-damaging behavior (Bagley et al.,1994; Fergusson et al., 1996) and increased rates of sexual adjustment problems (Fergusson, Horwood & Lynskey, 1997). Previous findings were mostly similar with current finding.

Conclusion
Though it is very difficult to establish a causal relationship between childhood abuse and current mental health problems, it can be assumed from the current study that mental health problem of young adults is connected with childhood abuse. As the 73.33% university female students had history of abuse so it is expected that most of our university female students are bearing a strong vulnerable factors for developing mental health problems like anxiety, depression, relationship problems etc. There are other questions like cognitive mechanism, coping strategies, etc are also very important which were not addressed in this research. So it is recommended to develop an appropriate measure for preventing mental health problems among female students as well as to design more comprehensive study for better understanding of this phenomenon with larger samples.

References


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Job Performance of the Medical Representatives in Relation to Big Five Personality Factors


Managing Psychological Problems of Patients with Essential Hypertension

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Abstract
The main purpose of the present study was to explore the psychological problems and to see the impact of psychological management in reducing those psychological problems experienced by the patients diagnosed as having essential hypertension. The sample of the study comprised 10 essential hypertension patients selected from 'Bangladesh Society of Hypertension', Dhaka. Among the participants 4 were females and 6 were males and their age range was 25 to 60 years and their average age was 44.2 years. For collecting data in-depth interview along with some standardized assessment tools like, General Health Questionnaire (GHQ)-28 and Hospital Anxiety Depression Scale (HADS) were used. Besides, Blood pressure level and self rating (0-10 points) measures were also taken. Psychological problems of the sample and formulations thereof by the researchers were shared between them; treatment plans were scheduled according to the goals of interventions. Psychological intervention was employed to manage their psychological problems. The study revealed that the patients having essential hypertension experience psychological problems and that psycho-therapeutic intervention are effective in reducing considerably the psychological problems of such patients contributing significantly to overall and speedy improvement of their health.

Introduction
Hypertension, most commonly referred to as "high blood pressure", is a medical condition where blood pressure in the arteries is chronically elevated. Essential hypertension indicates that no specific medical cause can be found to explain such a patient's condition (http://www.wikipedia.org/wiki/Hypertension).

According to Oxford clinical handbook about 95 percent of people with high blood pressure have essential hypertension. Zaman and Rouf(1999) have done an analysis of all published data that appeared in indexed
journals, and observed that 11% of Bangladeshi adults suffer from essential hypertension.

One of the big problems with essential hypertension is that it hardly ever exhibits symptoms. That is why it is often called a "silent killer." Physical symptoms are headache, neck ache, dizziness, palpitation, shortness of breath, visual changes, and chest pain (http://www.wikipedia.org/wiki/Hypertension). Mental symptoms are decrease in alertness, mental sluggishness, frequent confusion, loss of recent memory, occasionally paranoid psychosis. (Morrison ; 1997).

Essential hypertension has many risk factors. Several studies over the years have shown that some factors are directly or indirectly in connection with the occurrence of essential hypertension. Several demographic characteristics are associated with developing essential hypertension such as the prevalence rate for essential hypertension increases as people get older, particularly after about 45 years of age. Socioeconomic status is any indicator of lifestyle. (Oscar et al.; 2000). Biological risk factors are important in hypertension; they include: positive family history of hypertension, obesity, dietary elements (high sodium intake, low potassium intake, high cholesterol intake), excessive alcohol use, tobacco use and cigarette smoking. Behavioral and psychological factors play important role for development of essential hypertension. (Estlera and Paratib; 2004). Lifestyle (lack of exercise, inactivity, eating habit), personality pattern Type A Behavior Pattern consists of three characteristics: competitive achievement orientation, time urgency and anger/ hostility (Chesney, Frautschi, & Rosenman, 1985; Friedman & Rosenman, 1974) and psychological stresses contribute to the development of essential hypertension (Pickering; 1990). Anxiety and depression are risk factors for essential hypertension (Markovitz, Jonas and Davidson; 2001). Expression of anger and suppression of aggression accelerate early development of essential hypertension (Perini, et al.; 1991).

The goal of essential hypertension treatment is to prevent morbidity and mortality rate associated with essential hypertension. For that reason pharmacological treatment, non-pharmacological treatment (life style modification, monitoring of BP and other risk factors) and psychological treatment strategies are employed to manage their problems.

Rationale of the study
The rationale of this study is to assess the need of psychological services for the patients with essential hypertension. Generally, psychological problems have negative impact on one’s economical, social, occupational and personal life. Along with the psychological problems, uncontrolled BP level can lead to severe physical complication also.

Another point is to make the health professionals aware about the psychological problems of people with essential hypertension so that they can refer the patients to mental health professionals-especially, clinical psychologist. Psychological treatment, especially, cognitive behavior therapy (CBT), can be helpful in managing their psychological problems effectively and therefore, in reducing the risk of other complications.

Objective

The objective of the study was to explore psychological problems of patients with essential hypertension and to see the impact of psychological management in reducing psychological problems of such patients.

The Investigation

The participants

The participants of this study were initially 15 patients, 10 males and 5 females, suffering from essential hypertension attending “Bangladesh Society of Hypertension” at Green Road, Dhaka. The sample of this study included essential hypertensive patients, regularly followed by their general practitioners with monthly measures of blood pressure for at least 2 years prior to the study. The subjects were referred to the researcher by their general practitioners. Five participants dropped out at the beginning of the therapy session. Ten participants, 4 females and 6 males were administered psychotherapeutic interventions for managing their psychological problems. Their age range was 25 to 60 and their average age was 44.2. Table 1 shows the demographic information of the participants.
### Table-1: Demographic information of the Participants

<table>
<thead>
<tr>
<th>Case no</th>
<th>Code no</th>
<th>Age</th>
<th>Sex</th>
<th>Birth order</th>
<th>Education</th>
<th>Occupation</th>
<th>Socio-economic status</th>
<th>Marital status</th>
<th>BP before session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>A</td>
<td>39</td>
<td>M</td>
<td>4th child among 6 siblings</td>
<td>M.A. Business</td>
<td>Middle class</td>
<td>Married</td>
<td>140/92.67mmHg</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>B</td>
<td>50</td>
<td>F</td>
<td>1st child among 7 siblings</td>
<td>Up to S.S.C Housewife</td>
<td>Upper middle class</td>
<td>Married</td>
<td>144/91.67mmHg</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>C</td>
<td>47</td>
<td>M</td>
<td>Only child</td>
<td>Up to primary Business</td>
<td>Middle class</td>
<td>Married</td>
<td>147.67/102.67mmHg</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>D</td>
<td>38</td>
<td>F</td>
<td>1st child among 5 siblings</td>
<td>Under S.S.C Housewife</td>
<td>Higher class</td>
<td>Married</td>
<td>144.33/92.33mmHg</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>E</td>
<td>50</td>
<td>M</td>
<td>1st child among 2 siblings</td>
<td>Mst Business</td>
<td>Middle class</td>
<td>Married</td>
<td>150/102mmHg</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>F</td>
<td>47</td>
<td>F</td>
<td>1st child among 3 siblings</td>
<td>Degree Service</td>
<td>Middle class</td>
<td>Married</td>
<td>140.67/93.33mmHg</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>G</td>
<td>32</td>
<td>M</td>
<td>1st child among 7 siblings</td>
<td>Mst. Service</td>
<td>Middle class</td>
<td>Married</td>
<td>138.33/91mmHg</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>H</td>
<td>53</td>
<td>M</td>
<td>7th child among 8 siblings</td>
<td>Hons. Service</td>
<td>Middle class</td>
<td>Married</td>
<td>138.33/93.33mmHg</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>I</td>
<td>46</td>
<td>F</td>
<td>Last child</td>
<td>Masters Service</td>
<td>Higher</td>
<td>Married</td>
<td>140/93mmHg</td>
<td></td>
</tr>
</tbody>
</table>
Design of the study

Single case study method was employed to explore psychological problems associated with essential hypertension and to provide psychotherapy accordingly. Pre/post design was used to see the effect of psychotherapeutic interventions in managing psychological problems.

Measures and means of collecting data:
The following measures were used for collecting data in this research:

1. Socio-demographic questionnaire
2. In-depth interview
3. General Health Questionnaire (GHQ 28)
4. Hospital Anxiety depression Scale (HADS)
5. Self-rating scale
6. Blood pressure measure

Socio-demographic questionnaire

Socio-demographic data of the research respondents was collected using socio demographic questionnaire including age, educational level, marital status, occupation, socio economic status and birth order, onset of the problem, level of presenting blood pressure, family history, weight, salt intake, types of physical exercise in order to see whether these variables are associated with essential hypertension.

In-depth interview

In-depth interview was used to explore the respondents’ psychological problems, predisposing, precipitating and maintaining factors of those problems and illness related thought, behavior and feelings by using a topic guide prepared by the researchers.

General Health Questionnaire (GHQ 28)

The GHQ is available in several different versions, ranging from 60 to 12 items in length. It is a self report inventory. (Goldberg,1978). A 28 version is available that provides sub scores profiles on somatic symptoms, anxiety,
social dysfunction and severe depression. It is the most widely used version. Banoo (2001) translated it into Bangla. The test-retest reliability was found to be 0.682 by Spearman’s rho, which was significant at 0.01 levels. (Banoo, 2001)

Hospital Anxiety Depression Scale (HADS)

The HADS was developed from its predecessor, the Leeds Scale for Depression and Anxiety, specifically for use with medically ill patients. (Zigmond and Snaith, 1983) To achieve this aim, the developers omitted items related to somatic problems, which potentially could be confounded with physical illness. It is a short, 14 item self report scale and provides scores on two dimensions: depression and anxiety. Chowdhury (1996) translated it into Bangla. The correlation co-efficient was found 0.76 for anxiety sub scale and 0.94 for depression subscale, which are satisfactory. (Chowdhury ; 1996).

Self-Rating Scale

It was an 11 point rating scale where ‘0’ refers to no problem and ‘10’ refers to severest problem reported by participants.

Overall Subjective Report

An overall subjective report was collected through participant’s verbal comment about effectiveness of the therapeutic interventions.

Blood Pressure Measure

The blood pressure of every subject was measured by a physician or trained nurse weekly.

Procedure

At the outset participants were selected purposefully with the help of blood pressure measure, GHQ-28 and pre-determined inclusion and exclusion criteria. Each of the respondents was asked to complete socio-demographic information according to socio demographic questionnaire prepared by the researcher. The investigation was carried out in two phases. First, in the assessment phase, to find out the psychological factors associated with essential hypertension, in-depth clinical interview was taken with the help of semi-structured interview schedule to collect necessary information for assessing their mental health state thoroughly. Objective and subjective measures were used to find out the psychological problems of the participants and the severity of those problems. Each participant was asked at the first session to provide base line rating of their problems, to fill in HADS and GHQ-28 to collect quantitative base line measures. Second, the therapy was held in individual sessions. This was
followed by case conceptualization. After taking proper assessment formulation sharing and treatment goal was set collaboratively, cognitive behavior therapy was employed to the patients of this study to manage their psychological problems. At the end of the therapy sessions blood pressure was measured. In the last session the researcher took post measures using the same instruments administered in the first session. Follow up session was taken after one month of intervention.

The Results

Table 2 presents problems of ten cases categorized into five domains such as behavioral, affective, cognitive, physiological and social.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>Follow up session</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Behavioral domain</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deteriorated performance</td>
<td>(8 out of 10),</td>
<td>Deteriorated performance</td>
<td>(2 out of 8),</td>
</tr>
<tr>
<td>Avoid social interactions</td>
<td>(7 out of 10),</td>
<td>Avoid social interactions</td>
<td>(3 out of 7),</td>
</tr>
<tr>
<td>Sexual problem (2 out of 10)</td>
<td></td>
<td>Sexual problem (1 out of 2),</td>
<td></td>
</tr>
<tr>
<td>Crying (2 out of 10),</td>
<td></td>
<td>Crying (0 out of 2),</td>
<td></td>
</tr>
<tr>
<td>Passivity (2 out of 10),</td>
<td></td>
<td>Passivity (0 out of 4),</td>
<td></td>
</tr>
<tr>
<td>Aggressive behavior (2 out of 10),</td>
<td></td>
<td>Aggressive behavior (0 out of 2),</td>
<td></td>
</tr>
<tr>
<td>Passive aggressive behavior (1 out of 10),</td>
<td></td>
<td>Passive aggressive behavior (0 out of 1),</td>
<td></td>
</tr>
<tr>
<td><strong>Affective domain</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low mood (9 out of 10),</td>
<td>Low mood (1 out of 9),</td>
<td></td>
<td>Low mood (3 out of 9),</td>
</tr>
<tr>
<td>Guilty feelings (5 out of 10),</td>
<td></td>
<td>Guilty feelings (1 out of 5),</td>
<td>Guilty feelings (0 out of 5),</td>
</tr>
<tr>
<td>Irritation (9 out of 10),</td>
<td>Irritation (3 out of 9),</td>
<td></td>
<td>Irritation (1 out of 9),</td>
</tr>
<tr>
<td>Anger(6 out of 10),</td>
<td>Anger (1 out of 6),</td>
<td></td>
<td>Anger (2 out of 6),</td>
</tr>
<tr>
<td>Restlessness(9 out of 10),</td>
<td>Restlessness (1 out of 9),</td>
<td></td>
<td>Restlessness (2 out of 9),</td>
</tr>
<tr>
<td>Fear of dying (1 out of 10),</td>
<td>Fear of dying (0 out of 1),</td>
<td></td>
<td>Fear of dying (0 out of 1),</td>
</tr>
<tr>
<td>Anxiety about family(2out of 10),</td>
<td>Anxiety about family (0 out of 2),</td>
<td></td>
<td>Anxiety about family (0 out of 1),</td>
</tr>
<tr>
<td>Anxiety about physical condition(2 out of 10),</td>
<td>Anxiety about physical condition (0 out of 2),</td>
<td></td>
<td>Anxiety about physical condition (0 out of 2),</td>
</tr>
<tr>
<td>Helplessness (1 out of 10),</td>
<td>Helplessness (0 out of 2),</td>
<td></td>
<td>Helplessness (0 out of 2),</td>
</tr>
<tr>
<td>Loss of pleasure(5 out of 10),</td>
<td>Loss of pleasure (0 out of 1),</td>
<td></td>
<td>Loss of pleasure (0 out of 1),</td>
</tr>
<tr>
<td>Feeling tensed (3 out of 10),</td>
<td>Feeling tense (0 out of 3),</td>
<td></td>
<td>Feeling tense (0 out of 3),</td>
</tr>
<tr>
<td>Frustration(3 out of 10),</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive domain</td>
<td>Frustration (1 out of 3), Loss of pleasure (0 out of 5), Feeling tense (2 out of 3), Frustration (1 out of 3),</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-blame (7 out of 10), Thinking errors (10 out of 10), Recurrent thought of death (1 out of 10), Fear of losing self control (1 out of 10), Memory problem (7 out of 10), Lack of confidence (1 out of 10), Low self esteem (2 out of 10), Fear of being criticize (1 out of 10), Concentration problem (6 out of 10), Flashback (1 out of 10), Impatience (2 out of 10), Ambitiousness (2 / 10), Hostility (1 / 10),</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-blame (0 out of 7), Thinking errors (0 out of 10), Recurrent thought of death (0 out of 1), Fear of losing self control (0 out of 1), Memory problem (2 out of 7), Lack of confidence (0 out of 1), Low self esteem (0 out of 2), Fear of being criticize (0 out of 1), Concentration problem (1 out of 6), Flashback (0 out of 1), Impatience (0 out of 2), Ambitiousness (0 / 2), Hostility (0 / 1),</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-blame (1 out of 7), Thinking errors (1 out of 10), Recurrent thought of death (0 out of 1), Fear of losing self control (0 out of 1), Memory problem (1 out of 7), Lack of confidence (0 out of 1), Low self esteem (0 out of 2), Fear of being criticize (0 out of 1), Concentration problem (1 out of 6), Flashback (0 out of 1), Impatience (1 / 2), Ambitiousness (0 / 2), Hostility (0 / 1),</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social domain</th>
<th>Disrupted interpersonal relation with- Spouse (8 out of 10) Children (2 out of 10) Family members (2 out of 10) Colleagues (1 out of 10) Impaired social life (6 out of 10),</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disrupted interpersonal relation with- Spouse (1 out of 8) Children (1 out of 2) Family members (0 out of 2) Colleagues (0 out of 1) Impaired social life (1 out of 6),</td>
<td></td>
</tr>
<tr>
<td>Disrupted interpersonal relation with- Spouse (1 out of 8) Children (1 out of 2) Family members (1 out of 2) Colleagues (0 out of 1) Impaired social life (1 out of 6),</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physiological domain</th>
<th>Chest pain (6 out of 10), Headache (9 out of 10), Neck ache (7 out of 10), Sleep problem (5 out of 10), Tremor (2 out of 10), Breathing difficulties (1 out of 10),</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain (1 out of 6), Headache (2 out of 9), Neck ache (3 out of 7), Sleep problem (1 out of 5), Tremor (0 out of 2), Breathing difficulties (0 out of 1),</td>
<td></td>
</tr>
<tr>
<td>Chest pain (1 out of 6), Headache (3 out of 9), Neck ache (2 out of 7), Sleep problem (1 out of 5), Tremor (0 out of 2), Breathing difficulties (0 out of 1),</td>
<td></td>
</tr>
</tbody>
</table>
It can be seen from Table 2 that there are differences in behavioral, affective, cognitive, social and physiological domains in the pre intervention, post intervention and follow up sessions.

Table 3 shows differences in negative thought patterns of the patients with essential hypertension at pre and post intervention phases.

**Table-3: Difference in negative thought patterns of patients with essential hypertension at pre and post intervention phases**

<table>
<thead>
<tr>
<th>Pre intervention</th>
<th>Post intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will develop severe disease</td>
<td>If follow &amp; comply with treatment will be fine</td>
</tr>
<tr>
<td>Life is not worth living</td>
<td>Life is enjoyable</td>
</tr>
<tr>
<td>Are sinners</td>
<td>Not sinners</td>
</tr>
<tr>
<td>Family members are unhelpful</td>
<td>Family members are helpful</td>
</tr>
<tr>
<td>Less important in family</td>
<td>Important in family</td>
</tr>
<tr>
<td>Not valued in society</td>
<td>Valuable in society</td>
</tr>
<tr>
<td>Not respected</td>
<td>Respected</td>
</tr>
<tr>
<td>Irresponsible</td>
<td>Not irresponsible</td>
</tr>
<tr>
<td>Alone</td>
<td>Not alone</td>
</tr>
<tr>
<td>Unable to do things</td>
<td>Able to do things</td>
</tr>
<tr>
<td>Not happy in life</td>
<td>Possible to be happy in life</td>
</tr>
<tr>
<td>Failure in life</td>
<td>Able to be successful in life</td>
</tr>
<tr>
<td>Should not rely on others</td>
<td>Possible to rely on others</td>
</tr>
<tr>
<td>No one likes me</td>
<td>Others like me</td>
</tr>
<tr>
<td>No one understands</td>
<td>Possible to make others understand</td>
</tr>
<tr>
<td>As a person unfortunate</td>
<td>Not totally unfortunate person</td>
</tr>
</tbody>
</table>

The above Table shows differences in negative thoughts or hot thoughts of the patients in the pre intervention and post intervention phase. In the pre intervention session most of the clients perceived the events and the world negatively and in the post intervention they modified their negative automatic thoughts positively.

Table-4 presents differences in blood pressure level of the participants.

**Table-4: Differences in blood pressure level**

<table>
<thead>
<tr>
<th>Case no</th>
<th>Pre-intervention session</th>
<th>Post-intervention session</th>
<th>Follow-up session</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Systolic</td>
<td>Diastolic</td>
<td>Systolic</td>
</tr>
</tbody>
</table>
The above Table shows differences in blood pressure level in the pre-intervention, post-intervention and follow up sessions. It is seen that the improvement has occurred after psycho-therapeutic interventions.

**Figure 1 shows differences in overall subjective rating of 10 cases in pre intervention, post intervention and follow up sessions by the participants:**

The above figure shows differences in overall subjective rating of problems by the participants. It is seen that the improvement have occurred after psycho-therapeutic intervention.

**Figure 2 presents the severity of the problems in pre-intervention, post-intervention and follow-up sessions assessed by Hospital Anxiety Depression Scale (HADS).**
It appears that improvement occurred after psycho-therapeutic intervention.

Severity of the problems in pre-intervention, post-intervention and follow-up sessions assessed by General Health Questionnaire (GHQ) is shown in Figure 3.

![Figure 3: Assessment of severity of the problems in pre – post intervention and follow up session by statistical scale of GHQ-28](image)

The figure 3 represents the progress report on General Health Questionnaire (GHQ) of 10 cases.

**Discussion**

The findings of this study seem to be interesting. Psychological problems found in 10 cases with essential hypertension impacted behavioral, affective, motivational, cognitive and social domains. The study also indicated some thinking errors or cognitive distortions of the participants. It focused on the psychological factors associated with essential hypertension. The findings of this study correspond to those of the studies by Perini, et al. (1991), Lijing, et al. (2003) and Jonas, et al. (1997).
conceptualization of essential hypertension is a multi-factorial disease which involves physiological and psychological/behavioral factors.

In respect of age difference psychological problems with essential hypertension were mostly found in the middle aged participants. The study revealed that housewives faced different kind of psychological problems than working women because working women get better social network than housewives. Behavioral and psychological factors play an important role in the development of essential hypertension (Eslera, and Paratib, 2004).

Research has shown that high level of stress is associated with essential hypertension (Mannuck, 1994, Sherwood and Turner, 1995). Most of the participants in this study were leading a stressful life. Those life stresses generated essential hypertension. The participants who were showing influence of low job control in the workplace e.g. business or private job, showed high perceived stress (Steptoe, & Willemsen; 2004). Three patients out of 10 in this study were found to exhibit characteristics of Type ‘A’ behavior pattern. These patients showed less assertive behavior.

The present study further showed that early experience of psychological disturbances predisposed the patients to develop psychological problems. Negative events exaggerated psychological disturbances. Non supportive family environment also played an important role for developing psychological problems. The patients had psychological disturbances for a long time.

Managing psychological problems took 3 to 10 sessions for different cases. Following psychological treatment the participants of this study demonstrated increased performance level, increased social interaction, improved relation with their spouses, were able to engage in various activities, able to deal with people assertively and were able to concentrate. Most of the affective symptoms were reduced and the respondents felt better than before. Some physiological symptoms disappeared, some of the symptoms were reduced and they were well motivated to do things and enjoyed their activities. Modification of cognitive distortions followed psychological intervention.

Psychological management can reduce psychological problems as well as reduce blood pressure. Other research works support these findings (Wolfgang, et al. 2001; Joy, et al. 1998 & Garcia, et al. 1998). Management of type ‘A’
behavior pattern succeeded significantly in reducing systolic and diastolic blood pressure level. This finding corresponds to that of a study by Bennett P. et al. (1991). The results of this study suggest that psychological management have pervasive effects that spread across several risk factors apart from high blood pressure, especially across psychological factors e. g., self-control behaviors that determine dietary and related lifestyle habits known for their direct effects on BP control. This finding is consistent with that of a study by Lindquist, Beilin, & Knuiman (1997).

The above findings of the study underline the fact that managing psychological problems of patients with essential hypertension is important to reduce their problems and also to control their blood pressure level.

Implications of the results of this study

Essential hypertension is a manageable disease. There are multiple risk factors. For better control of hypertension and better outcome, these risk factors must be managed properly and accurately for better and enduring outcome. The findings of this study highlight the importance of awareness among health professionals and related people about psychological problems of patients with essential hypertension for proper treatment and management of such patients. So, it is important to incorporate psychological services in health care system.

Limitations of this study and suggestions for future research

First of all, the research was conducted on a small sample. As the study was qualitative and did not include a representative sample of patients with essential hypertension, the research only showed some trends and ideas about some patients. The researchers do not claim that the findings could be generalized.

Another limitation of the study is that the sample did not include any case from lower socio-economic status. So, it is not possible to understand the nature of the psychological problems and the effectiveness of psychological intervention among essential hypertension patients belonging to other socio-economic status such as lower socio-economic status group. Another limitation of this study was that the sample did not include any subjects from rural areas.

References


Oscar, A. Carretero, MD; Suzanne Oparil MD Circulation. 2000; 101:329© 2000 American Heart Association,Inc.


Job Performance of the Medical Representatives in Relation to Big Five Personality Factors


Cases

**Fig-1:** Differences in overall subjective rating of the problems by the participants

Cases

**Fig-2:** Assessment of severity of the problems in pre – post intervention and follow up session by statistical scale of HADS

Cases

**Fig-3:** Assessment of severity of the problems in pre – post intervention and follow up session by statistical scale of GHQ-28

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>15</th>
<th>29</th>
<th>49</th>
<th>61</th>
<th>71</th>
<th>85</th>
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<td></td>
<td>98</td>
<td>99</td>
<td>100</td>
<td>101</td>
<td>102</td>
<td>103</td>
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</table>
Psychometric Evaluation of the Bangla Beck Scale for Suicide Ideation

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and

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University of Dhaka

Abstract
The present study adapted the Beck Scale for Suicide Ideation (BSS) for use in Bangladesh following standard psychometric principles. Forty-six ideators between the ages of 13 to 23 years completed the Bangla version of the BSS. The internal consistency reliability as measured by Cronbach alpha was .83. Five types of validity for the BSS were considered: content, concurrent, construct, discriminant, and factorial and all were found satisfactory. Thus, the Bangla BSS appeared psychometrically sound and hence culturally suitable. Therefore, professionals working on mental health issues can use the BSS as a screening tool to identify individuals with risk for suicide attempts.

Introduction
Suicide is commonly understood as the intentional killing of oneself. It is committed mainly due to altruistic, egoistic, or anomic reasons. When the victim is motivated by some social ideals and purposes to sacrifice life for a cause is termed altruistic. Certain cults even train their votaries to sacrifice life for eternal bliss and to commit suicide, either individually or en masse. In egoistic suicide, the individual suffers from lack of adequate integration into society and support of the collective forces that prevent suicide. Anomic suicide emanates when the individual’s desires and ambitions cannot find satisfaction.

The tendency to commit suicide among the people of Bangladesh is on the rise in recent years. As reported in newspapers, the majority of them are either married women or female students of schools, colleges and universities. The reason behind their committing suicide is primarily psychological. More specifically, overwhelming majority of them had chosen the path of self-destruction following rejection by their husbands, friends, or peers.
It is known that suicide ideation is a risk factor for suicide attempt that in turn increases risk for suicide death (reviewed in King, 1997). Whereas suicide ideation is more common among girls than among boys in adolescence (Evans, Hawton, Rodham, & Deeks, 2005) the association of ideation with suicide attempts does not differ by sex (Andrews & Lewinsohn, 1992; Reinherz, Tanner, Berger, Beardslee, & Fitzmaurice, 2006). Moreover, although girls more often attempt suicide (Evans et al., 2005), boys more often die by suicide since they more often employ lethal means to do so (King, 1997). Thus, detecting severity of the current plan for committing suicide by patients is one of the important initial steps to help prevent suicide attempt and/ or suicide death.

The Bangladesh Health and Injury Survey reported that girls aged 14 to 17 are more likely to commit suicide, and attempt suicide than boys. It also reported that more than 2200 children committed suicide in one year – or about six per day. Of those six, four were female. Suicide is the biggest killer among this age group. [Bangladesh Health and Injury Survey Report on Children, UNICEF and Government of Bangladesh, 2005.]

About 6.5 million people of Bangladesh are suicide-prone. A total of 128.8 people among 100,000 commit suicide a year. Among them, 89 per cent are women, most of whom are unmarried. This disclosure came from a survey report of Shaheed Suhrawardy Medical College Hospital, Dhaka under the auspices of Health Department which was revealed at a press conference in the capital, Dhaka. The six-member team led by Dr AHM Feroz and Dr SM Nurul Islam of the medical college conducted the survey at Mominpur union of Chuadanga district from January to April 2010. Deterioration of inter-personal relation, long-term problem and drug addiction are the main causes of suicide, according to the report.

It appears from the above reports that the incidence of suicide attempt or suicide in Bangladesh is increasing at an alarming rate. It is implied that suicide can be prevented if suicidal ideators can be identified. Identifying ideators require the use of instruments having acceptable psychometric properties. A review of literature indicates unavailability of valid instrument that can be used to gauge severity of suicidal ideation among the people of Bangladesh. It seems necessary to assemble, adopt, or adapt a test to measure suicide ideation. It is well known that assembling or in other words constructing a new test involves huge time, energy, and economy. It is also known that differences in language and culture are barrier to adopt a test. Therefore, it is parsimonious to adapt a test that is easy to administer, score and interpret. More importantly, it is
worthwhile to adapt a test that has been validated and cross validated several times. Since the Beck Scale for Suicide Ideation is widely used, the present research was undertaken to adapt the BSS for use in Bangladesh.

The BSS consists of 21 groups of statements or items. The first 19 items measure gradations of the severity of suicidal wishes, attitudes, and plans to commit suicide during the past week. Within each group, the statements reflect increasing gradation, from 0 to 2 of this severity. In order, the 19 items measure the following facets of suicide ideation: Wish to live, Wish to die, Reasons for living or dying, Active suicide attempt, Passive suicide attempt, Duration of suicidal thoughts, Frequency of ideation, Attitude toward ideation, Control over suicidal action, Deterrents to attempt, Reasons for attempt, Specificity of planning, Availability or opportunity of method, Capability to carry out attempt, Expectancy of actual attempt, Extent of actual preparation, Suicide note, Final acts, and Deception and concealment. The last two items (items 20 and 21) which ask about the number of previous suicide attempts and the seriousness of intention to die associated with last attempts help the clinician discover important background characteristics, but are not used in calculating the BSS total score.

The BSS begins with 5 screening items assessing wish to live, wish to die, reasons to live versus reasons to die, active suicide ideation (e.g., "I have a moderate to strong desire to kill myself"), and passive suicidal ideation (e.g., "I would not take the steps necessary to avoid death if I found myself in a life-threatening situation"). If a respondent totally denies active or passive suicidal ideation, s/he is instructed to skip the next 14 BSS items, which address specific information about the respondent’s plans and attitudes. Otherwise, the respondent rates next 14 BSS items. Every respondent is asked to rate item 20, and any respondent who has previously attempted suicide is requested to rate item 21. For a suicide ideator (that is, a respondent who has rated all of the items), the severity of suicidal ideation is calculated by summing the ratings for the first 19 items. Items 20 and 21 are not included in the score. The total BSS score can range from 0 to 38 points. The BSS takes approximately 10 minutes to administer.

The authors of the BSS suggest that the instrument is best used to detect and measure severity of suicidal ideation, which is considered to be an indication for suicide risk (Beck and Steer, 1991). However, the authors caution that the BSS should not be the only instrument used for assessing suicidality, and suggest that "endorsement of any BSS item may reflect the presence of suicide intention and should be investigated by the clinician" (Beck and Steer, 1991).
The BSS was found to have high internal consistency and moderately high correlations with clinical ratings of suicidal risk and self-administered measures of self-harm. Furthermore, it was sensitive to changes in levels of depression and hopelessness (Beck Depression Inventory and Hopelessness Scale, respectively) over time. Its construct validity was supported by two studies by different investigators testing the relationship between hopelessness, depression, and suicidal ideation and by a study demonstrating a significant relationship between high level of suicidal ideation and "dichotomous" attitudes about life and related concepts on a semantic differential test. Factor analysis yielded three meaningful factors: Active Suicide Desire, Specific Plans for Suicide, and Passive Suicide Desire.

The BSS is one of the more thorough instruments for assessing severity of suicide ideation, and one of the only assessment devices for assessing passive suicidal ideation. The total score yields a severity score, but individual items can be used as screens for active suicidal ideation, passive ideation, and past attempts. The items assessing thoughts of death are separate from items assessing suicidal ideation per se. The active suicide ideation screening item 4 refers to "desire to kill myself," which implicitly assumes some rumination associated with "non-zero intent to kill oneself." The follow-up Item 15 even more clearly addresses issues of intent (e.g., "I am sure I shall make a suicide attempt").

**Method**

The adaptation process of the BSI consisted of the following six steps:

**Step one: Ensuring construct equivalence**

Despite variations in severity, age of onset, and rate of suicide ideation among different cultural and linguistic groups, the construct ‘suicidal ideation’ itself is universal and hence applicable equally to our cultural context. This argument can be substantiated by the very existence of the term suicide in our literature. Therefore, the construct suicide ideation can be studied in our language and culture with the same definition applied elsewhere.

**Step two: Forward translation**

Two translators, without consulting each other, independently translated the English version questionnaire to Bangla. Though their mother tongue was Bangla, they were proficient in English. They were knowledgeable about the principles of test construction/adaptation and were familiar with the construct being measured. The translators worked together on their translated versions
and, by arriving at a consensus, selected the best words, expressions, or items. Thus, the preliminary Bangla version inventory was prepared.

**Step three: Back translation**

A professor of psychology, proficient in both English and Bangla language, was approached to translate the Bangla version into English. A panel consisting of two psychologists having expertise in psychometrics and proficiency in English judged the equivalence of the original English version and the back-translated version of the inventory. A perfect agreement between the members about the similarity of the back-translated version of the inventory with the original one provided evidence for the correctness of the forward translation. The Bangla version was then subjected to subsequent steps.

**Step four: Pre-testing**

A pre-testing was carried out by administering the Bangla version inventory on a purposive sample of 10 suicidal ideators aged between 13 to 20 years. Only those who wanted to volunteer to fill in the questionnaires upon hearing the objectives of the study were finally selected. An examiner, trained in assessment procedure, administered the inventory in a classroom setting. At first, the respondents were asked to read the instructions on the top of the inventory very carefully. Also the examiner verbally explained what was to be done, emphasizing that there were no right or wrong responses. The examiner directed the respondents to select honestly only one statement from every group of responses. During the test, the respondents were allowed to ask questions about words or concepts which they did not understand. The words or expressions that they asked about were noted by the administrator. Respondents were also individually interviewed to enquire as to whether they have found any word, concept, or expression confusing, difficult, unacceptable or offensive. Based on the procedure, some statements were revised before determining reliability of the inventory. The adapted Bangla version of BSS is enclosed in the Appendix.

**Step five: Determining reliability**

The reliability data are based on the responses to the first 19 items of the BSS by the reliability sample. A total of 56 suicidal ideators were approached to complete the questionnaire. However, 46 respondents completed the questionnaire properly. Of them 24 were males and 22 females. The age of the respondents ranged from 13 to 23 years with a mean age of 16.76 years. The education level of the respondents ranged from high school to university (24 studying at 9-10 grade, 17 at college and the rest at university). Of them, 2 were married and 44 were unmarried. Eighteen of them were first and second born and others were
third, fourth, fifth, sixth, and seventh born children of the family. No significant correlation of age, gender, education, birth-order, and family income with suicide ideation was observed in the present study. Corrected item-total correlation coefficients were satisfactory for each item and internal consistency reliability for the inventory as measured by Cronbach alpha was .83 (see Table 1). The coefficient alpha for the original English version inventory was .87 ($N = 52$ outpatient ideator sample).

**Table 1: Means, Standard Deviations, % Endorsement, and Corrected Item-Total Correlations for the Beck Scale for Suicide Ideation for Reliability Sample**

<table>
<thead>
<tr>
<th>Items</th>
<th>$M$</th>
<th>$SD$</th>
<th>% Endorsement</th>
<th>$r_{tot}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wish to live</td>
<td>0.91</td>
<td>.69</td>
<td>28.3</td>
<td>52.2</td>
</tr>
<tr>
<td>2. Wish to die</td>
<td>1.24</td>
<td>.71</td>
<td>15.2</td>
<td>45.7</td>
</tr>
<tr>
<td>3. Reasons for living or dying</td>
<td>1.24</td>
<td>.71</td>
<td>15.2</td>
<td>45.7</td>
</tr>
<tr>
<td>4. Active suicide attempt</td>
<td>1.04</td>
<td>.78</td>
<td>28.3</td>
<td>39.1</td>
</tr>
<tr>
<td>5. Passive suicide attempt</td>
<td>1.22</td>
<td>.55</td>
<td>6.5</td>
<td>65.2</td>
</tr>
<tr>
<td>6. Duration of suicide thoughts</td>
<td>0.91</td>
<td>.78</td>
<td>34.8</td>
<td>39.1</td>
</tr>
<tr>
<td>7. Frequency of ideation</td>
<td>0.63</td>
<td>.68</td>
<td>47.8</td>
<td>41.3</td>
</tr>
<tr>
<td>8. Attitude toward ideation</td>
<td>1.20</td>
<td>.65</td>
<td>13.0</td>
<td>54.3</td>
</tr>
<tr>
<td>9. Control over suicidal ideation</td>
<td>1.02</td>
<td>.68</td>
<td>21.7</td>
<td>54.3</td>
</tr>
<tr>
<td>10. Deterrents to attempt</td>
<td>1.22</td>
<td>.63</td>
<td>10.9</td>
<td>56.5</td>
</tr>
<tr>
<td>11. Reasons for attempt</td>
<td>1.39</td>
<td>.58</td>
<td>4.3</td>
<td>52.2</td>
</tr>
<tr>
<td>12. Specificity of planning</td>
<td>1.02</td>
<td>.71</td>
<td>23.9</td>
<td>50.0</td>
</tr>
<tr>
<td>13. Availability or opportunity of method</td>
<td>1.02</td>
<td>.68</td>
<td>21.7</td>
<td>54.3</td>
</tr>
<tr>
<td>14. Capability to carry out attempt</td>
<td>1.04</td>
<td>.73</td>
<td>23.9</td>
<td>47.8</td>
</tr>
<tr>
<td>15. Expectancy of actual attempt</td>
<td>0.96</td>
<td>.70</td>
<td>26.1</td>
<td>52.2</td>
</tr>
<tr>
<td>16. Extent of actual preparation</td>
<td>0.65</td>
<td>.67</td>
<td>45.7</td>
<td>43.5</td>
</tr>
<tr>
<td>17. Suicide note</td>
<td>0.61</td>
<td>.77</td>
<td>56.5</td>
<td>26.1</td>
</tr>
<tr>
<td>18. Final acts</td>
<td>0.65</td>
<td>.64</td>
<td>43.5</td>
<td>47.8</td>
</tr>
<tr>
<td>19. Deception and concealment</td>
<td>0.96</td>
<td>.76</td>
<td>30.4</td>
<td>43.5</td>
</tr>
<tr>
<td>Total BSS Score</td>
<td>17.70</td>
<td>6.22</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. $N = 46$. Cronbach coefficient alpha = .83*  
**Step six: Determining validity**
Five types of validity for the BSS were considered: content, concurrent, construct, discriminant, and factorial. A sample comprising 50 students with suicide ideation was asked to complete the BSS questionnaire along with a Personal Information Form (PIF). However, 46 students completed the questionnaires properly. Of them, 24 were males and 22 females. The age of the respondents ranged from 14 to 28 years with a mean age of 19.8 years. The education level of the respondents was 9-10 grade (24%), college (41%) and university (35%). Two of them were married and 44 were unmarried. Eight were first born, 22 second born, 11 third born, and the rest were fourth, fifth, sixth, and seventh born children of the family.

**Content Validity**
The same analytical results showing that the original BSS measures attitudes, plans, and behaviors relevant to suicide ideation apply to the Bangla BSS because the latter represents the linguistic and cultural transformation of the former.

**Concurrent Validity**
The concurrent validity of the BSS with the Suicide Ideation Symptom (item 9) of the BDI was evaluated. For 46 suicide ideators the correlation of the BSS with BDI Item 9 was .41. The correlation was significant beyond the 0.01 level, one-tailed test. The similar results were reported by Beck, Steer, and Ranieri (1988).

**Construct Validity**
The construct validity of the BSS with the BDI and the BHS was evaluated (see Table 2). The BDI and the BHS were translated and administered along with the BSS in order to assess construct validity. The alpha coefficients for the BDI and BHS were .93 (N = 46, number of items 21) and .91 (N = 46, number of items 20), respectively. Corrected item-total correlations ranged from .43 to .76 (M = .62, SD = .08) for the BDI and from .22 to .76 (M = .57, SD = .15) for the BHS. The correlations of the BSS with the BDI and the BHS were .79 and .66 (p < .01, one-tailed test), respectively. The correlation between the BSS and the BDI excluding the BDI Suicide Ideation symptom (item 9) was .79 (p < .01, one-tailed test).

**Discriminant Validity**
The ability of the BSS to differentiate suicide ideators with physical and mental illness from suicide ideators without them was assessed. The point bi-serial correlations of the BSS with physical illness, frustration, and mental illness (absence = 0, presence = 1) were .094, .515, and .563 (see Table 2). It is evident from the results that the BSS could differentiate suicide ideators with frustration and mental illness from ideators without frustration and mental illness. The
nonsignificant correlation between the BSS and physical illness is reasonable since minor physical problem has nothing do with the ideation of suicide.

**Table-2: Correlations of the Beck Scale for Suicide Ideation with Selected Background Characteristics and Other Instruments**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Ideation Sample (N = 46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex (Male = 0, Female = 1)</td>
<td>-.003</td>
</tr>
<tr>
<td>Age (years)</td>
<td>.042</td>
</tr>
<tr>
<td>Physical Illness (Absence = 0, Presence = 1)</td>
<td>.094</td>
</tr>
<tr>
<td>Frustration (Absence = 0, Presence = 1)</td>
<td>.515(**)</td>
</tr>
<tr>
<td>Mental Illness (Absence = 0, Presence = 1)</td>
<td>.563(**)</td>
</tr>
<tr>
<td>Beck Depression Inventory (BDI)</td>
<td>.789(**! !)</td>
</tr>
<tr>
<td>BDI excluding Suicide Ideation Item 9</td>
<td>.789(**! !)</td>
</tr>
<tr>
<td>BDI Suicide Ideation Item 9</td>
<td>.411(**)</td>
</tr>
<tr>
<td>Beck Hopelessness Scale (BHS)</td>
<td>.663(**)</td>
</tr>
</tbody>
</table>

** Correlation is significant at the 0.01 level, one-tailed test

**Adjustment for Sex, Age, and Physical Illness**

The correlations of sex, age, and physical illness with BSS scores were calculated for the validity sample (N = 46). The Pearson point biserial correlation between sex (male = 0, female = 1) and BSS scores was -.003. The Pearson product moment correlation between age (years) and BSS scores was .042. The Pearson point biserial correlation between physical illness (absence = 0, presence = 1) and BSS scores was .094. None of these correlations is significant (see Table 2).

**Factorial Validity**

A principal-components analysis with a varimax rotation on the responses to the first 19 BSS items by the ideation sample (N = 46) was conducted. The results are shown in Table 3. There were five components with eigenvalues > 1.0, and these five components explained 64.62 % of the total variance.

Component I had salient loadings for the following BSS items: Deterrents to attempt (item 10), Availability or opportunity of method (item 13), Capability to carry out attempt (item 14), Expectancy of actual attempt (item 15), and Extent of actual preparation (item 16).

Component II had salient loadings for the following BSS items: Duration of suicide thoughts (item 6), Frequency of ideation (item 7), Reasons for attempt (item 11), and Specificity of planning (item 12).

Component III had salient loadings for the following BSS items: Wish to live (item 1), Wish to die (item 2), Active suicide attempt (item 4), and Final acts (item 18).
Component IV had salient loadings for the following BSS items: Reasons for living or dying (item 3), Passive suicide attempt (item 5), Attitude toward ideation (item 8), and Suicide note (item 17).

Component V had salient loadings for the following BSS items: Reasons for living or dying (item 3) and Deception and concealment (item 19).

**Table 3: Varimax-Rotated Principle-Components Loadings for the Beck Scale for Suicide Ideation for Validity Sample**

<table>
<thead>
<tr>
<th>Item</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>H²</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Wish to live</td>
<td>.080</td>
<td>.526</td>
<td>.683</td>
<td>.176</td>
<td>.071</td>
<td>.79</td>
</tr>
<tr>
<td>2. Wish to die</td>
<td>.079</td>
<td>.163</td>
<td>.794</td>
<td>.185</td>
<td>-.027</td>
<td>.70</td>
</tr>
<tr>
<td>3. Reasons for living or dying</td>
<td>.005</td>
<td>.166</td>
<td>.094</td>
<td>.588</td>
<td>.507</td>
<td>.64</td>
</tr>
<tr>
<td>4. Active suicide attempt</td>
<td>.142</td>
<td>.036</td>
<td>.719</td>
<td>.036</td>
<td>.093</td>
<td>.55</td>
</tr>
<tr>
<td>5. Passive suicide attempt</td>
<td>.034</td>
<td>.078</td>
<td>.426</td>
<td>.594</td>
<td>.148</td>
<td>.56</td>
</tr>
<tr>
<td>6. Duration of suicide thoughts</td>
<td>.337</td>
<td>.689</td>
<td>.146</td>
<td>-.130</td>
<td>.024</td>
<td>.63</td>
</tr>
<tr>
<td>7. Frequency of ideation</td>
<td>-.094</td>
<td>.823</td>
<td>.196</td>
<td>.174</td>
<td>.167</td>
<td>.78</td>
</tr>
<tr>
<td>8. Attitude toward ideation</td>
<td>.365</td>
<td>.192</td>
<td>.255</td>
<td>.581</td>
<td>.254</td>
<td>.64</td>
</tr>
<tr>
<td>9. Control over suicidal ideation</td>
<td>.417</td>
<td>.196</td>
<td>.193</td>
<td>.213</td>
<td>.324</td>
<td>.40</td>
</tr>
<tr>
<td>10. Deterrents to attempt</td>
<td>.606</td>
<td>.005</td>
<td>.163</td>
<td>.417</td>
<td>-.135</td>
<td>.59</td>
</tr>
<tr>
<td>11. Reasons for attempt</td>
<td>.047</td>
<td>.617</td>
<td>.179</td>
<td>.345</td>
<td>-.352</td>
<td>.66</td>
</tr>
<tr>
<td>12. Specificity of planning</td>
<td>.357</td>
<td>.497</td>
<td>-.128</td>
<td>.233</td>
<td>.193</td>
<td>.48</td>
</tr>
<tr>
<td>13. Availability or opportunity of method</td>
<td>.778</td>
<td>-.203</td>
<td>-.089</td>
<td>.314</td>
<td>-.155</td>
<td>.78</td>
</tr>
<tr>
<td>14. Capability to carry out attempt</td>
<td>.579</td>
<td>.102</td>
<td>.378</td>
<td>-.037</td>
<td>-.077</td>
<td>.50</td>
</tr>
<tr>
<td>15. Expectancy of actual attempt</td>
<td>.681</td>
<td>.303</td>
<td>.048</td>
<td>.093</td>
<td>.397</td>
<td>.72</td>
</tr>
<tr>
<td>16. Extent of actual preparation</td>
<td>.735</td>
<td>.312</td>
<td>.148</td>
<td>.060</td>
<td>.165</td>
<td>.69</td>
</tr>
<tr>
<td>17. Suicide note</td>
<td>.317</td>
<td>.139</td>
<td>.005</td>
<td>.779</td>
<td>.028</td>
<td>.73</td>
</tr>
<tr>
<td>18. Final acts</td>
<td>.398</td>
<td>-.251</td>
<td>.451</td>
<td>.359</td>
<td>.371</td>
<td>.69</td>
</tr>
<tr>
<td>19. Deception and concealment</td>
<td>.012</td>
<td>.027</td>
<td>.060</td>
<td>.130</td>
<td>.862</td>
<td>.76</td>
</tr>
</tbody>
</table>

% Common: 25.56, 19.2, 20.54, 22.24, 12.44, 100.0
% Total: 31.65, 10.7, 8.71, 7.59, 5.91, 64.62

Note. N = 46. Salient loadings > .45 are in bold.

**Discussion**

The purpose of the present study was to adapt the Beck Scale for Suicide Ideation for use in Bangladesh. A widely accepted guideline for the adaptation process as recommended in the literature (Hambleton, 2005) was followed in the present study. The internal consistency reliability of the BSS as demonstrated in the present study appeared high (Cronbach alpha = .83) according to the criteria of George and Mallery (2003) who provided the following rules of thumb: “α ≥ .9 – Excellent, .9 > α ≥ .8 – Good, 8 > α ≥ .7 – Acceptable, .7 > α ≥ .6 – Questionable, .6 > α ≥ .5 – Poor, and .5 > α – Unacceptable” (p. 231). It is noteworthy that the alpha coefficient of the original BSS was .87 which is negligibly higher than that of the Bangla BSS. Additionally, corrected item-total correlation for each item of
the scale was satisfactory indicating that all items are important in the cultural context of Bangladesh.

Evidences for the validity of the Bangla BSS came from five sources. Firstly, the Bangla BSS was found to have content validity since items of the scale were culturally and linguistically transformed. Secondly, the BSS was positively and significantly correlated with the Suicide Ideation Symptom of the BDI that evidences for the concurrent validity. The magnitude of the correlation coefficient for the original scale was slightly higher ($r = .56$, for 52 outpatient ideators). Thirdly, correlations of the BSS with the BDI and the BHS were significant ($r = .79$ and $r = .66$, respectively; $p < .01$, one-tailed test) providing evidences for the construct validity. The magnitudes for the original scale were much lower ($r = .27$ and $r = .25$, respectively; $p < .05$, one-tailed test). The higher value of the coefficient indicates that depression as well as hopelessness contributes more to suicidal ideation for the sample of Bangladesh. Fourthly, significant correlations of the BSS with frustration and mental illness indicate that the BSS could differentiate suicide ideators with frustration and mental illness from ideators without frustration and mental illness, respectively. Finally, five components of the BSS items clustered by a principal component analysis can explain 64.62% of the total variance which is slightly higher than the original one (64.2%). Additionally, sex and age were not significantly related to the BSS scores for the present sample which is consistent with the original scale. On the whole, the instrument yielded similar results. Thus, the Bangla BSS appeared to measure what it was actually designed to measure and therefore, can be confidently but cautiously used by the clinicians to help screen the suicidal ideators.

The present study however is not beyond its limitations. One big limitation was the small sample size included in the present study. As suicidal ideators are intermixed with general population it was very difficult to find out them and approach to volunteer for the study. Future research should be conducted on a larger sample having broad age range and diverse socio-demographic categories. Despite the limitations, the psychometric properties of the Bangla BSS are directly comparable and in some aspects superior to the original version.

References

Job Performance of the Medical Representatives in Relation to Big Five Personality Factors


Appendix: Bangla Beck Scale for Suicidal Ideation

অন্যান্য করে সতর্কতার সাথে প্রত্যেকটি এস্প্রেস উক্তিগুলো পড়ুন। যে উক্তিটি আপনার গত এক সপ্তাহের (আজকের দিনহই) অনুভূতিকে সবচেয়ে ভালোভাবে বর্ণনা করে, প্রতি এস্প্রেস থেকে শুধু সেই উক্তিটি বৃত্তাকার চিহ্ন দ্বারা শনাক্ত করুন।

1. (ক) আমার বাচ্চার মেটামুটি প্রবল ইচ্ছে আছে।
   (খ) আমার বাচ্চার সামান্য ইচ্ছে আছে।
   (গ) আমার বাচ্চার কোন ইচ্ছে নেই।

2. (ক) আমার মরার কোন ইচ্ছে নেই।
   (খ) আমার মরার সামান্য ইচ্ছে আছে।
   (গ) আমার মরার মেটামুটি প্রবল ইচ্ছে আছে।

3. (ক) আমার বেঁচে থাকার কারণগুলো মরে যাবার কারণগুলোর চেয়ে অধিকতর জেরালো।
   (খ) আমার বেঁচে থাকার কারণগুলো এবং মরে যাবার কারণগুলো প্রায় সমান জেরালো।
   (গ) আমার মরে যাবার কারণগুলো বেঁচে থাকার কারণগুলোর চেয়ে অধিকতর জেরালো।

4. (ক) আমার আত্মহত্যা করার কোন ইচ্ছে নেই।
   (খ) আমার আত্মহত্যা করার সামান্য ইচ্ছে আছে।
   (গ) আমার আত্মহত্যা করার মেটামুটি প্রবল ইচ্ছে আছে।

5. (ক) জীবননায়ক পরিস্থিতিতে পড়লে আমি জীবন বাচানোর চেষ্টা করব।
   (খ) জীবননায়ক পরিস্থিতিতে পড়লে বাচা মরা আমি ভাগের উপর ছেড়ে দিব।
   (গ) জীবননায়ক পরিস্থিতিতে পড়লে আমি মৃত্যুকে এড়ানোর চেষ্টা করব না।

যদি আপনি ৪ ও ৫ নং উস্তা এস্প্রেস থেকে ক নং বাক্ত পছন্দ করে থাকেন তাহলে সরাসরি ২০ নং বাক্ত চলে যান।
আর যদি ৪ ও ৫নং থেকে খ অথবা গ নং বাক্ত পছন্দ করে থাকেন তবে ৬ নং থেকে প্রথম করস্তম্ভ এবং এগিয়ে যান।

6. (ক) আমার আত্মহত্যার চিন্তা ক্ষণস্থায়ী।
   (খ) আমার আত্মহত্যার চিন্তা কিছুটা স্থায়ী।
   (গ) আমার আত্মহত্যার চিন্তা দীর্ঘস্থায়ী।

7. (ক) কন্দাচিৎ অথবা অক্সাম আমি আত্মহত্যার চিন্তা করি।
   (খ) আমি প্রায়ই আত্মহত্যার চিন্তা করি।
   (গ) আমি অবিরত আত্মহত্যার চিন্তা করি।

8. (ক) আত্মহত্যার ধারণা আমার নিকট গৃহীত নয়।
   (খ) আত্মহত্যার ধারণা আমার নিকট গৃহীত নয় বর্জনীয়ও নয়।
   (গ) আত্মহত্যার ধারণা আমার নিকট গৃহীত।

9. (ক) আমি আত্মহত্যা করা থেকে নিজেকে সরিয়ে রাখতে পারব।
   (গ) আমি আত্মহত্যা করা থেকে নিজেকে সরিয়ে রাখতে পারব কিনা এ ব্যাপারে আমি সন্ধিহান।
   (গ) আমি আত্মহত্যা না করে পারব না।

10. (ক) আমার পরিবার, বন্ধু বাচ্চব, ধর্ম এবং আত্মহত্যার বার্থ প্রচেষ্টাপ্রসূত সমাজে ক্ষত বা পীড়া ইত্যাদির বিভিন্নতা আমি আত্মহত্যা করব না।
    (খ) আমার পরিবার, বন্ধু বাচ্চব, ধর্ম এবং আত্মহত্যার বার্থ প্রচেষ্টাপ্রসূত সমাজে ক্ষত বা পীড়া ইত্যাদির বিভিন্নতা আমি আত্মহত্যার ব্যবহার কিছুটা উদ্দেশ্য।
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(গ) আমার পরিবার, বন্ধু বাড়ী, ধর্ম এবং আত্মহীনতার বাছাই প্রচেষ্টায় স্থায়ী ফ্র্যাঙ্ক বা পীড়া ইত্যাদির বিশেষণায় আমি আত্মহীনতার বাবার উদ্যোগ নেই।

11। (ক) আমার আত্মহীনতা করতে চাওয়ার মূল কারণগুলো অন্যকে প্রভাবিত করা যেমন, করা উপর প্রতিশোধ নেয়া, কাউকে অতিক্রম করে, আমার প্রতি অন্যের মনের আকর্ষণ করা ইত্যাদি।

(খ) আমার আত্মহীনতা করতে চাওয়ার কারণ একথা অন্যকে প্রভাবিত করা নয়; আমার সমস্যাগুলোর সমাধান করাও বাড়।

(গ) আমার আত্মহীনতা করতে চাওয়ার কারণ মূলত আমার সমস্যাগুলো থেকে মুক্ত পাওয়া।

12। (ক) কীভাবে আমি আত্মহীনতা করব সে ব্যবহার আমার সুনির্দিষ্ট কোন পরিকল্পনা নেই।

(খ) কীভাবে আমি আত্মহীনতা করব সে ব্যবহার মনের ব্যবস্থার সাথে ভেবেছি কিন্তু এখনও বিস্তারিত কাজ করিনি।

(গ) কীভাবে আমি আত্মহীনতা করব সে ব্যবহার আমার সুনির্দিষ্ট একপক্ষ আছে।

13। (ক) আমার আত্মহীনতা করার সুযোগ নেই বা আত্মহীনতার প্রতি নাগাদ নেই।

(খ) আমি যে পর্যন্ত আত্মহীনতা করব তা সময় সাপেক্ষ এবং বস্তুত সে পর্যন্ত আমার ব্যবহারের সুযোগ নেই।

(গ) আমি যে পর্যন্ত আত্মহীনতা করব সে পর্যন্ত আমার নাগাদ আছে কিংবা থাকবে এবং তা ব্যবহারের সুযোগ আছে কিংবা থাকবে।

14। (ক) আমার আত্মহীনতা করার সাহস কিংবা দক্ষতা নেই।

(খ) আমার আত্মহীনতা করার সাহস কিংবা দক্ষতার ব্যবহারে আমি সদিদ্ধ।

(গ) আমার আত্মহীনতা করার সাহস এবং দক্ষতা আছে।

15। (ক) আমি আত্মহীনতার চেষ্টা করব এটা প্রত্যাশা করি না।

(খ) আমি আত্মহীনতার চেষ্টা করলে কিনা এ ব্যবহারে আমি সদিদ্ধ।

(গ) আমি যে আত্মহীনতার চেষ্টা করব সে ব্যবহারে আমি নিশ্চিত।

16। (ক) আমি আত্মহীনতা করার কোন প্রক্রিয়া নেইনি।

(খ) আমি আত্মহীনতা করার কিসু প্রক্রিয়া নিয়েছি।

(গ) আমি আত্মহীনতা করার প্রক্রিয়া সাধারণ অধিক সম্পূর্ণ শেষ করেছি।

17। (ক) আমি আত্মহীনতা পূর্ব চিন্তাতে এখনও লিখিনি।

(খ) আমি আত্মহীনতা পূর্ব চিন্তাতে লিখার কথা ভেবেছি অথবা লিখার কথা ভেবেছি কিন্তু এখনও শেষ করিনি।

(গ) আমি আত্ম হীনতা পূর্ব চিন্তাতে কিছু কে ভেবেছি।

18। (ক) আত্মহীনতা করার পর কি ঘটবে সে ব্যবহারে আমি কোন ব্যবস্থা নেইনি।

(খ) আত্মহীনতা করার পর কি ঘটবে সে ব্যবহারে আমি কিছু ব্যবস্থা নেয়ার কথা ভেবেছি।

(গ) আত্মহীনতা করার পর কি ঘটবে সে ব্যবহারে আমি নিদীর্ঘকাল কিছু ব্যবস্থা নিয়েছি।

19। (ক) আমি আমার আত্মহীনতা করার ইচ্ছা লোকজনের কাছে লুকাই নি।

(খ) আমি আমার আত্মহীনতার ইচ্ছায় লোকজনকে বলব কিনা সে ব্যবহারে ইতস্ততাবদ্ধ করি।

(গ) আমি আমার আত্মহীনতা করার ইচ্ছা লোকজনের কাছ থেকে লুকিয়ে রেখেছি।

20। (ক) আমি কখনও আত্মহীনতার চেষ্টা করিনি।

(খ) আমি একবার আত্মহীনতার চেষ্টা করেছি।

(গ) আমি দুই বা ততোধিক বার আত্মহীনতার চেষ্টা করেছি।

যদি আপনি পূর্ব আত্মহীনতার প্রচেষ্টা করে থাকেন তবে পরবর্তী ব্যক্তিগত থেকে ১টি বাকী পছন্দ করান।

21। (গ) শেষবার আত্মহীনতা প্রচেষ্টার সময় আমার মৃদুতার ইচ্ছা কম ছিল।
(খ) শেষবার আত্মহত্যা প্রচেষ্টার সময় আমার মৃত্যুর ইচ্ছে মাঝারি ধরনের ছিল।
(গ) শেষবার আত্মহত্যা প্রচেষ্টার সময় আমার মৃত্যুর ইচ্ছে প্রবল ছিল।