# Standardized Outcomes Measure in Urdu – Clinical Outcomes in Routine Evaluation Outcome Measure – Translation, Cultural Challenges and Implications

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## Abstract

One global public health challenge is the increasing recognition of real magnitude of mental health problems and the need for effective, and affordable interventions and prevention strategies. The development of such resources requires usable measurement tools which should ideally bring some inter-cultural and trans-linguistic comparability of scores while also being genuinely culturally appropriate in the target populations. The current study describes the translation and adaptation of a widely used self-report measure, the CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure) from English into Urdu. The translation and the whole process was run across both the UK and Pakistan. This process followed a stringent protocol involving 20 independent forward translations, a focus group discussion and finally two back translations and a vital qualitative field testing with ten people across Pakistan. A number of items were challenging to translate into Urdu, some for linguistic reasons and more for cultural reasons and the qualitative field testing proved vital to achieve a final version that was acceptable across diversity of geography and language (Urdu as first, second or even third language). The findings provide reassuring evidence that the translation was culturally appropriate and successful in achieving a measure that is now available to use worldwide, without reproduction fees.

**Keywords:** CORE-OM, Culture, Language, Mental Health, Translation, Self-report Questionnaire, Urdu

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## Introduction

Through the latter half of the 20th Century and the 21st Century the seriousness of mental health (MH) as a public health issue has moved from being largely a concern of the global north to being understood as a genuinely global challenge (Usmonov & Elov, 2022). However, over the same period, mental health has shifted from being seen largely in a biomedical model to in a biopsychosocial frame (Bolton, 2022), understanding that MH has deep environmental roots, not only in trauma and poverty but also in culture and cultural and religious attitudes to MH problems. In parallel with this, use of affordable tools to measure change across mental health interventions has expanded, and again from a global north perspective to a world perspective. These changes have been associated with increasing recognition that constructions of mental health (MH) and

wellbeing vary widely across countries as do levels of and organization of HM services. Similarly, it has been understood that transferring measures across languages and cultures requires more than translation and backtranslation. Recognizing these developments, we describe the translation and adaptation of a self-report measure, the CORE-OM a measure proven to fit with these developments, for use in Urdu in Pakistan and across the Pakistani diaspora. In the work we look at the linguistic and also the cultural challenges. As well as suggesting that a good translation resulted, we believe the findings will have general utility for translations of instruments into other languages of the subcontinent and more widely in moving measures from a very Anglo-Saxon, global North repository to a world resource (Usmonov & Elov, 2022).

Pakistan encompasses a population of multiple ethnicities on a land of ancient empires, sultanates and civilizations that contribute to its diverse culture (Rahman, 1997) that is important to recognize in measure translation (Roysircar, 2005). The population of about 200 million people (Sikandar, 2020) includes between 15 (Javed et al., 2020) and 24 million (WHO, 2016) people with mental health issues; the report argued that mental health issues constitute almost 4% of the national disease and in 2019, Pakistan recorded 19,331 suicides (WHO, 2016). However, there is a marked gap between the population's need and mental health services the WHO-AIMS Report (2009) recorded 3,729 outpatient mental health facilities in Pakistan, 500 psychiatrists, 400 psychologists and 1400+ other health professionals (Sikandar, 2020).

Mental health services in Pakistan were traditionally delivered by shamans and spiritual healers (Ansari, 2015) and a substantial number of Pakistani citizens and the Pakistani diaspora believe that mental illnesses are caused by possessions of the soul by djinns or spirits and appropriate to be treated by faith healers. In Karachi alone there are about 400+ such healers (Global Human Rights Defence, 2022). Traditionally, across the subcontinent and of course in many countries, people exhibiting psychotic experiences were pushed away from mainstream societies into seclusion (Amir-Ud-Din, 2020). Their sufferings were often attributed to the sins committed by them or their families causing immense amounts of shame to be attached to mental health problems generally and strong and common stigmatization continues (Amir-Ud-Din, 2020; Kroll & Bachrach,1984).

At the time of the partition of British occupied India in 1947, there were only three mental health facilities (Lahore, Peshawar and Hyderabad) called 'madhouses' in Pakistan (Mubbashar, 2003). Later, psychiatric units were established in many major hospitals but even currently, due to the lack of awareness of services and high illiteracy, individuals suffering from mental health issues are sometimes left chained at shrines, beaten or burnt to relieve the symptoms (Afridi, 2008). However, this is changing and the first Pakistani government national program for mental health was launched in 1986 and was then included in subsequent national development program. The mental health law of 2001 endorses research-based understanding of mental illnesses and the basic rights of mentally ill people. Since 2008, all mental health facilities are visited and reviewed and a national human rights committee regulates all MH facilities (WHO-AIMS, 2009) and behavioral sciences are compulsory in the curriculum

of all medical schools (Nazar et al. 2007). The 18th amendment to the constitution highlighted health after which provincial Mental Health Acts were revised (Sindh in 2013 and Punjab in 2014) (Mubbashar, 2003) and the number of MH facilities and training is growing and having an impact: recent research showed that 16% of patients referred to spiritual healers in one district of Pakistan were assigned medical diagnoses and sent to the psychiatrists (Mubbashar, 2003). Currently, MH disorders most commonly reported in Pakistan include depression and anxiety but schizophrenia, conversion disorder, obsessive compulsive disorder and post-traumatic stress disorder are also common (Khalily, 2011).

In the light of the prevalence of mental health issues in Pakistan, the need to address quality evaluation and intervention of patients in mental health facilities is high. The Pakistani population can gain great benefit from a standardized tool for assessment in clinics in their own language i.e., Urdu. Therefore, this paper aims to translate and adapt an already existing, psychometrically robust instrument CORE-OM. The next section will cover the methods of translating and adapting CORE-OM to Urdu language and Pakistani culture respectively.

Urdu is the national language of Pakistan (Muzaffar & Behera, 2014) and belongs to the Indo-Aryan group of languages widely spoken in Pakistan where it is the national and official language (with English) despite being the first language for only about 7% of the population. Seventy million people use Urdu as their first language and a further 100 million people use it as their second language (Augustyn, 2022; Muzaffar & Behera, 2014; Statista Research Department, 2020). There are well known challenges assessing world

rankings of languages but one (Islam, 2011) puts Urdu as the 20th most spoken language in the world.

Urdu is very different from the English language, the dominant language of MH measures and root language of the CORE system. It differs in grammatical structure, vocabulary and socio-cultural roots (Irshad et al., 2018). Urdu has lexical and semantic aspects relating to traditions of hospitality and collectivistic family systems (Irshad et al., 2018). These are all challenges for translation into Urdu.

Clearly it is ideal if languages and cultures can make use both of measures designed and arising out of the local culture and language and translations of measures in global use so we looked for possible local alternatives to the CORE-OM. Psychological testing has expanded rapidly in Pakistan in the last few decades with indigenous development of measures e.g. for resilience (Zikriya et al., 2020), depression and anxiety (Ali et al.,1998), altruism (Anum et al., 2021), anger (Kazmi & Siddqui, 2020), emotional intelligence (Batool & Khalid, 2011) and deliberate self-harm (Gul & Najam, 2019). Translations of measures into Urdu date back to the 1970s, when the MMPI was translated by a Pakistani psychologist (Saeed et al., 2001) and more recent translations include that of the "Big Five Personality Scale (Khan et al., 2019), Criminogenic Cognition Scale (Jamil & Fatima, 2018), Coping Strategy Scale (Abbasi & Loona, 2021), Post-Partum Bonding Questionnaire (Sattar et al., 2021), Mental Health Continuum short form (Faran et al., 2021), Life Orientation Test (Waseem et al., 2021) and Psychosomatic Symptoms Scale (Shah et al., 2022). However, we found no questionnaire designed to measure change in psychological interventions that was in

global use, free of reproduction fees and available in Urdu. Given the rapidly increasing delivery of psychotherapy other psychological interventions (Masud, 2019) Pakistan needs such a measure to track and evaluate change.

In the light of this it can be seen that translations of measures into Urdu are more complex than many measure translations, having to consider the multiple ethnicities and language variation across the population of intended users and also having to address the varied quality of education and differences in mental health awareness and stigma across Pakistan (Afridi, 2008; Rahman, 1997). Maintaining cultural sensitivity in measure translation requires awareness of the diversity of cultures (Laher & Cockcroft, 2017), respect for the population's ethical values and understanding linguistic differences (Foxcraft, 2011). Culturally sensitive referential data should only be developed using measures developed or translated with these issues in mind (Melikyan et al., 2019).

This paper describes how we worked with these challenges for the translation of the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM). The CORE-OM is the central instrument of the CORE system. That system (https://www.coresystemtrust.org.uk/) combined the idea of a "core battery" of change measures (Barkham et al., 1998; Mellor-Clark et al., 1999) with simple per-client methods alongside statistical methods (Evans et al., 1998) and the idea of "Practice Based Evidence (PBE)" as a complement to Evidence Based Practice (Margison et al., 2000) and creation of "Practice Research Networks (PRNs)" (Audin et al., 2001) . The CORE-OM (Evans et al., 2000, 2002) is a 34-item self-report questionnaire scale. The CORE-

OM and CORE system approach have obvious advantages for Pakistan: although the measure is copyright, protecting it against the development of many incompatible forms and poor translations, it is free of reproduction fees if the original forms and translations are used unchanged. Shortened forms exist: two parallel 18 item forms for use alternately to minimize memory effects, and a 10 item form (Barkham et al., 2013) are each for clinical use. In addition a 14 item shortened form for general population survey work (Evans et al., 2005) was created. All four shortened forms are entirely derived from the full CORE-OM so available in translation when the CORE-OM has been translated. Related measures have been developed for young people (Twigg et al., 2009, 2016) and people with mild to moderate learning difficulties (Barrowcliff et al., 2018; Brooks et al., 2013; Marshall & Willoughby-Booth, 2007). A standard translation procedure, reported here, has been used to create over 35 translations and the translations are in use around the world. For a recent comprehensive review of that literature of over 700 peer-reviewed publications see (Paz et al., 2025) and a linked searchable database at https://shiny.psyctc.org/apps/COREpapers1/. Psychometric explorations of the measures in many translations and different datasets from different countries have shown good properties.

This paper presents the use of the Core System Trust; CST, 2015) translation procedure (https://www.coresystemtrust.org.uk/home/translations/cst-translation-policy/) to create an approved Urdu translation of CORE-OM for the use of the Pakistani population and Urdu speaking people around the globe. Despite translations of

the CORE-OM into British Sign Language (Rogers, Evans, et al., 2013; Rogers, Young, et al., 2013) and Chinese (Zhang et al., 2019) and of the YP-CORE into Arabic (Yassin & Evans, 2021) most previous CORE translations have been into European languages and European settings. (The complexities of the use of Spanish outside Europe are being actively explored: (Evans et al., 2021; Paz et al., 2020, 2021; Paz & Evans, 2023). Building on that work, translation of the CORE-OM into Urdu was a pathfinder for the CORE system, and for translation and adaptation of international measures for psychological therapies in the subcontinent.

The CORE translation protocol starts with exploration of the challenges of the particular translation, described above and then proceeds to independent forward translations, focus-group discussion of those forward translations followed by qualitative field testing with participants selected to address likely language and comprehension diversity and backward translations (Core System Trust, 2015). Translations must be co-led by a team of one or more native speaker local leads and a member of CORE System Trust with experience of previous translations. Throughout the process there is expert involvement but also stress on involving lay people as these are the user population for the measure.

**Method**

The first stage on the CORE translation protocol, researching the cultural and linguistic issues, has been summarized above the next stage was forward translations.

**Forward Translations**

This involves collection of independent forward translations by people who speak good English but who have the target language as their first or equal first language. The minimum number to satisfy the protocol is five but that is acknowledged to be a very bare minimum only likely to suffice in very linguistically and culturally homogenous target populations with high rates of literacy. The translators must include one professional interpreter or translator, at least one mental health professional and at least two lay people. However, forward translators are sought trying to cover as comprehensively as possible differences in language, locality, education and familiarity with MH problems.

Twenty translations of the CORE-OM from English into Urdu were obtained from individuals with sufficient fluency in English and Urdu and at least intermediate level (high school) education. The twenty comprised containing fifteen school teachers, three doctors and two people with 12 years of formal education. They were briefed that the questionnaire was a measure of stress, poor well-being and difficulties coping and aimed at the as much of the Urdu speaking population as could read the measure, not just a well-educated group such as those doing the translations. The translators were assured that their own translations would be kept anonymous and confidential, asked to agree to renounce any copyright claims on their translation in return for the assurance that the final measure would always be free to use.

**Focus Group**

This involved discussion of the twenty translations and particularly their differences. The group included one member of CST who observed the process and answered occasional questions generally about why the English had been written as it had and to try to help when the Urdu speakers were divided about the best

approximations to the English in Urdu. The six bilingual participants were of Pakistani origin, resident in the UK and were fluent in Urdu and English. The age range of the bilingual participants was 22 to 52 years. They included:

1. A male Psychiatrist who had worked both in Pakistan and the UK.
2. A female Psychiatrist who had worked both in Pakistan and the UK.
3. A male warehouse manager born and brought up in Pakistan who had attended college (equivalent to A-levels, age 17/18) in Pakistan employed in the UK for the a few years.
4. A female care worker born and brought up in Pakistan and now living and working in the UK for a few years.
5. A female primary school teacher, born, brought up and educated to degree level in Pakistan now living and working in the UK for the several years.
6. A male retail supervisor born, brought up educated in Law (B.A, LLB) in Pakistan now living and working in the UK for several years.

The anonymized translations were given to the group and each part, items, time frame ("Over the last week"), response levels and the introduction discussed and then the whole reviewed after a first preferred translation of each part was agreed within the group. The work took twelve hours across one day. Issues emerging in the meeting are summarized below.

**Qualitative Field Testing and Back Translation**

In a slight variation from the usual CORE translation protocol, there was a further stage of discussion of the translation that had emerged from the focus group in the UK when it was reviewed in Pakistan. Small changes were felt necessary to correct for some homogeneity of origins from within Pakistan among the UK focus group and forward translators. These were agreed between the new, Pakistan based, collaborators and the two main leads of the UK based work, who by then had returned to Pakistan. The translation that resulted went into qualitative field testing.

**Qualitative Field Testing**

This was done in Pakistan after some further amendments of the wording emerging from the UK based focus group. Ten individuals were selected for the field testing, chosen to have a mix of both genders, an age range from 17 to over 60 years of age and to include at least one person from each province of Pakistan. Participants were required to have passed at least 5th grade education (completed at 9 years of age) as comprehension reading gains fluency by this age and to be a native speaker of Urdu with it as their first, second or third spoken language as shown in Table 1.

**Table 1**

*Demographics of Qualitative Field-Testing Participants (N=10)*

| | Gender | Age | First language | Where is Urdu in their languages | Province of Origin | Current Location | Education | Occupation |
|---|---|---|---|---|---|---|---|---|
| 1 | Male | 17 | Pashto | Second | KPK | Mansehra | 5th Grade | Household help |
| 2 | Male | 55 | Punjabi | Second | Punjab | Islamabad | Graduation | Manager IT Operations |
| 3 | Male | 46 | Urdu | First | Sindh | Karachi | Graduation | Self-employed |
| 4 | Female | 61 | Punjabi | Second | Punjab | Lahore | Masters | Retired Professor |
| 5 | Male | 52 | Punjabi | Second | Punjab | Lahore | Masters | Lawyer |
| 6 | Female | 25 | Urdu | First | Sindh | Karachi | Graduation | Student |
| 7 | Female | 28 | Urdu | First | Punjab | Faisalabad | Masters | Lecturer |
| 8 | Male | 45 | Balochi | Third | Balochistan | Quetta | Matriculation | Self-employed |
| 9 | Female | 33 | Pashto | Second | KPK | Nowshera | Masters | Housewife |
| 10 | Female | 59 | Balochi | Second | Balochistan | Peshawar | Matriculation | Unemployed |

Participants were identified with the help of students and by permission of Forman Christian College University (FCCU) administration. FCCU takes students from all over Pakistan and students from each province were invited to participate in this research and those who agreed were asked to connect the researcher with relatives and neighbors so that the age and education spread desired could be met. As a result of the COVID-19 pandemic the interviews were conducted via video/audio calls.

The field testing was by 'Talk Aloud Interviews': the aim of the research was explained and participants were told that there are no right or wrong answers to the interview questions and that all the data would be kept confidential. The participants were then asked to imagine someone with some stress answering the questions. They were asked to report to the interviewer what that individual might understand from the items of the questionnaire.

Probe questions then explored the level of understanding, difficulties and possible alternatives of the statements. These included:

- Is there anything that was difficult to read or was unclear? Would the person you are thinking of understand this?
- Is there anything that did not seem good? Responses were transcribed and discussed with the representative from CST and led to revisions.

**Back Translation and Finalization of the Translation**

As per the CORE translation protocol the revised translation was back translated by two individuals competent in both Urdu and English language who had never seen the CORE-OM questionnaire. Finally, the CST representative, one MH professional from the focus group and the primary researcher reviewed the small differences between the backtranslations and the original English together with the feedback from the field testing and a final version agreed.

**Results**

The independent forward translations showed considerable diversity. The differences were discussed at length in the focus group. The participants agreed that some differences related to the ages and education of the translators and the participants in the focus group and were generally easily resolved after the participants were asked to focus less on their own views and more on some abstracted native Urdu speaker probably having less education than that of the translators and participants in the focus group. Other differences were felt simply to relate to the existence of considerable diversity in how things can, equally legitimately, be said in Urdu. Yet others, as has been seen for many translations of the CORE-OM related to the use in English of multiple words where many languages would only use one word, for example "alone and isolated", "tense, anxious or nervous" and to the use of "and" or "or" in such composites to tune the level of the item. Others related to whether some ideas in the English simply transliterate into Urdu or have to be translated more freely. Increasingly easily, over a twelve-hour period, differences were resolved to consensus on the most appropriate expression.

**Phase III: Qualitative Field Testing**

During qualitative field testing, three items were found difficult to understand by four of the ten participants. These items were items 5, 7 and 20. Item 5 contained the

English phrase 'totally lacking in energy' which it had already been recognized could not be translated exactly into Urdu. From an initial Urdu, translation, synonymous to power, the sentence was edited using an alternate word for energy '*tawanayi*' used in health and medicine. This suggestion was given by the fifth participant in the field testing. The new version was then used in later interviews and was considered appropriate by the rest of the participants. Likewise, the word 'cope' in item 7 could not be translated in a single word as Urdu no exactly equivalent word. The initial focus group translation suggested an Urdu word which was synonymous to 'facing problems' but was incomprehensible for three participants. In the light of the field testing the item was changed Urdu back translating as 'have been able to take control of things when they went wrong'. The initial translation of item 20 missed an article which was causing confusion for the participants. That article (*liye*) was then added to omit the grammatical error. Though understood, the expression of 'I have felt' in item 3 caused slight unease to some interviewees. It is not common in Urdu language to be so clear about one's feelings. Therefore, an alternate phrase that can be interpreted both as 'I think' and 'I feel' interchangeably, was used to make the sentence sound more subtle and acceptable. Another stylistic change was that 'unwanted thoughts' in item 13 was changed from one Urdu translation of the word 'thoughts' to another to sound more suitable, as Urdu language has more than one word for thoughts.

These stylistic changes made after the first three interviews were received with satisfaction from the rest of the participants. The statement about 'self-harm' (item No. 9) was received with surprise by two participants from Khyber Pakhtunkhwa and Balochistan. This may have been due to the infrequency and/or underreporting of self-harm attempts in these provinces of Pakistan. Item 26; 'I have thought I have no friends' made one participant smile and another pause. One said 'well…I don't have friends but I have people of other kinds to help me through rough time'. This statement is indicative of the multilayered interpersonal relationships that exist in the collectivistic culture of Pakistan.

Though there were minor differences between the back-translation and the original English, none were substantial enough to justify any changes and a final online discussion agreed the changes emerging from the qualitative field testing and reassured us that, despite the linguistic, historical, cultural and spiritual differences discussed above, it had proved possible to find a translation from the UK English original CORE-OM to an Urdu version usable in Pakistan and across the Pakistani diaspora.

**Discussion**

The majority of previous translations of the CORE-OM have been to other European languages, this translation into Urdu was a more protracted process partly because we were careful throughout to avoid assuming even that a translation of the measure into Urdu would be possible. However, the process started from the conviction of the Urdu speaking participants throughout the process that the translation *was* possible and the measure potentially meaningful and useful in Urdu, both in Pakistan and across the Pakistani diaspora.

That the initial focus group in the UK started with twenty independent forward translations and the focus group lasted twelve hours illustrate the lengths, it was

tried to capture issues challenging the translation and it is telling that even with that level of work, the resumption of the translation in Pakistan led to further changes in the draft translation even before the qualitative field testing. Interestingly, all the items that had most discussion in the focus group were tweaked further through the qualitative field testing. This underlines how translation is not a mechanical process but rather a process requiring depth consideration of language use in cultures and how the interacting forces within cultures can differ (Ayonrinde, 2003).

The issue with 'lack of energy' in item 5 emerged because energy is understood more as a physical than a mental issue in Pakistani culture and this in turn at least partly reflects that mental health is not prioritized as much as physical illnesses in Pakistan (Sikandar, 2020). It may also be due to the fact that people of a population with such a history of natural disasters, war on terror and socio-economic instability, may focus on physical survival to keep afloat.

The issue with the word 'coping' in item 7 was felt by the participants perhaps to coping has for centuries in Pakistan been more often about life and death challenges than in the UK where the CORE-OM had been designed. However, it is worth noting that discussions almost always emerge about this word in translations into European languages, most of which do not have an exact equivalent phrase or word, or not one in common use. Similarly, the stem 'I have felt that…' was received with unease explained as reflecting Pakistani people being less vocal than say British English speakers about their feelings (Fahd & Hanif, 2018) and are likely to interpret experiences using cognitive or behavioral frames: "I have thought" or "I

have done". Again, this is not unique to translation into Urdu and arose during the early translation of the CORE-OM into Norwegian (Skre et al., 2013) and has recurred in a number of other translations. In Pakistan it is only recently that particularly younger generations have become more expressive about their feelings and inner experiences perhaps affected de-stigmatization efforts made by the mental health professionals and the impact of social media. To what extent this represents "globalization" is a complex question.

Qualitative field testing also revealed how language is indicative of subtleties like latent interpersonal structures in a society. Having social support other than from friends caused two participants to suggest changes to item 26. In Pakistani culture like other collectivistic cultures, it is common to have close relationships that do not fall simply into friends and family ("kith and kin"). Extended family relatives (Rafique, 2017), colleagues, neighbors, members of same ethnic group or members of same religious or political party are likely to make sacrifices for each other which would be unusual in more individualist cultures. Sometimes, having a daughter of one town wedded in another town is sufficient for both the towns to be obligated to help each other through rough times.

**Conclusion**

It is concluded that that this extended translation process was necessary to ensure that linguistic, historical, socio-political and spiritual differences between the British English origins of the CORE-OM, and the complex target population of Pakistani and world-wide Urdu speakers were not such that a translation and transfer of the instrument would be inappropriate. The qualitative evidence of

the process is that it is not inappropriate but that the care taken, and participation of so many people, and not just of experts in mental health, was entirely necessary. It is worth mentioning that the instrument (available                                at https://www.coresystemtrust.org.uk/home/translations/urdu/) has already been used in one published study and a thorough quantitative exploration of the measure in Pakistani samples will be published separately.

**Ethics Statement**
All the ethical standards of APA were met. Informed consent was taken in written form from all the respondents to participate in this study.

**Contribution of Authors**
Easha Shahid: Conceptualization, Investigation, Methodology, Data Curation, Formal Analysis, Writing – Original Draft
Ivan Samuel Suneel: Methodology, Writing - Reviewing & Editing
Chris Evans: Conceptualization, Methodology, Writing - Reviewing & Editing, Supervision

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**Data Availability Statement**
The datasets of the current study are not available publicly due to ethical reasons but are available from the corresponding author [E.S.] upon the reasonable request.

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