ORIGINAL ARTICLE

GUIDELINES FOR THE PROCESS OF CROSS-CULTURAL ADAPTATION AND TRANSLATION OF THERAPEUTIC MODULES

Tania Qamar, Nabisah Ibrahim

School of Applied Psychology Social Work & Policy, University Utara-Malaysia

Background: Language is a very important aspect for the adaptation and translation process. For many people, their native language is not just a means of communication but a vessel of cultural identity and emotional expression. When individuals are experiencing the difficulties of life, they should have the chance to address them using a language that truly connects with their personal experiences. Adapting and translating therapeutic modules to align with cross-cultural settings is important to ensure effectiveness and practicality among different populations. The objective of this article is to provide the guidelines for the process of cross-cultural adaptation and translation-back-translation of the therapeutic modules, and also provide the guidelines to test the reliability and validity of the translated version of therapeutic modules. **Method.** The Back-to-Back translation model (10) was used in this study for the guidelines of adaptation and translation of therapeutic modules. Following the instructions in this document made the process of adaptation and translation simpler. **Results.** Results showed that the (10) is a significant model and provided a systematic and comprehensive way for adaptation and translation of therapeutic module with make little changes in reaction to feedback and cultural awareness. **Conclusion.** At the end, it emphasised how important it is to conduct an extensive study to determine the effectiveness and cultural compatibility of the updated modules. However, these principles ultimately enhance effective and inclusive health care, providing health professionals with a foundation for adapting and translating therapeutic processes to diverse cultural conditions.

Keywords: Cross-Cultural Adaptation and Translation; Translation-Back-Translation Model Guidelines; Therapeutic Modules

Citation: Qamar T, Ibrahim N. Guidelines for the Process of Cross-Cultural Adaptation and Translation of Therapeutic Modules. J Ayub Med Coll Abbottabad 2024;36(4):Epub, ahead of printing

DOI: 10.55519/JAMC-04-13584

INTRODUCTION

Language is a very important aspect for the adaptation and translation process. For many people, their native language is not just a means of communication but a vessel of cultural identity and emotional expression. When individuals are experiencing the difficulties of life, they should have the chance to address them using a language that truly connects with their personal experiences.[1] Translating therapeutic modules acknowledges this diversity, affirming the validity of various linguistic and cultural contexts in the realm of healing. The need to translate therapeutic modules into source languages other than the original language is increased with multicultural and global research programmes.[2,3] The majority of the modules were developed by English-speaking countries; however, it is essential to adhere to a specific procedure when adapting and translating a therapeutic module for use in a different country, culture, or language to ensure that it performs as well as the original.

The cross-cultural adaptations and translation of original work are important in many contexts, this is more evident in certain situations than in others. While developing a therapeutic module for use in a foreign region, the challenges of cultural adaptation and language translation are important to keep in mind. In order to avoid the possibility of systematic bias[4,5], there is need to pay attention to the sensitivity of cross-cultural differences. Such as, the most difficult aspects of translating from one language to another are expressing ideas precisely when there are no direct translations available, as well as maintaining consistency and clarity without changing the original meaning. In addition, in order to make therapeutic treatments truly resonate with different people, it is necessary to have a comprehensive knowledge of cultural norms, beliefs, and values.[6] Also, it is important to be sensitive and flexible when developing interventions to address the specific needs of different communities because there are different levels of challenges when considering healthcare systems, socioeconomic problems, and past experiences.

Besides, there is need to overcome these challenges during the cross-cultural adaptation and

translation of therapeutic modules. Overcoming challenges in cross-cultural adaptation and translation of therapeutic modules requires collaborative efforts, involving linguists, researchers, and community workers, considering cultural sensitivity, linguistic accuracy, and contextual relevance in the adaptation and translation process. Literature also identified important considerations for successful adaptation and translation, such as, to identify the ideal approach to intervention modification, all interventions should be linguistically, idiomatically, cognitively, and experientially similar.[7,8] During the cross-cultural adaptation and translation, the validity and reliability of the therapeutic module is also considered as an important aspect.

The International Society for Quality-of-Life Assessment (IQOLA) guidelines is use to assess the translation of a therapeutic module. IQOLA uses a three-stage process, the first of which provides an in-depth explanation of the translation process.[9] The following two stages include the verification and validation of the content, followed by establishing and verifying the normative values of the new edition. It has been seen that in literature, there are many guidelines for the adaptations and translations of different instruments, however, there is not any guideline for the translation and adaptation of therapeutic modules. Thus, the main objective of this study is to provide the guidelines for the process of cross-cultural adaptation and back-to-back translation of therapeutic modules, and, also provide the guidelines to test the reliability and validity of the translated version of therapeutic module.

MATERIAL AND METHODS

Brislin developed a model of back-to-back translation. This study provided the guidelines to use this back-to-back translation model for the adaptation and translation of therapeutic module.[10] The translation-back-translation approach model refers to the process of translating source material into the target language and then back into the original language.[10] In the translation-back-translation method, two or more bilingual translators work independently to translate each step from the source language to the target language. Following that, these translators resolve issues related to the final result in an integrated way.[11] The complete step by step guidelines are provided in the conceptual framework model of the present study. Figure 1 discusses the conceptual framework of the translation-back-translation model's five stages (Figure-1).

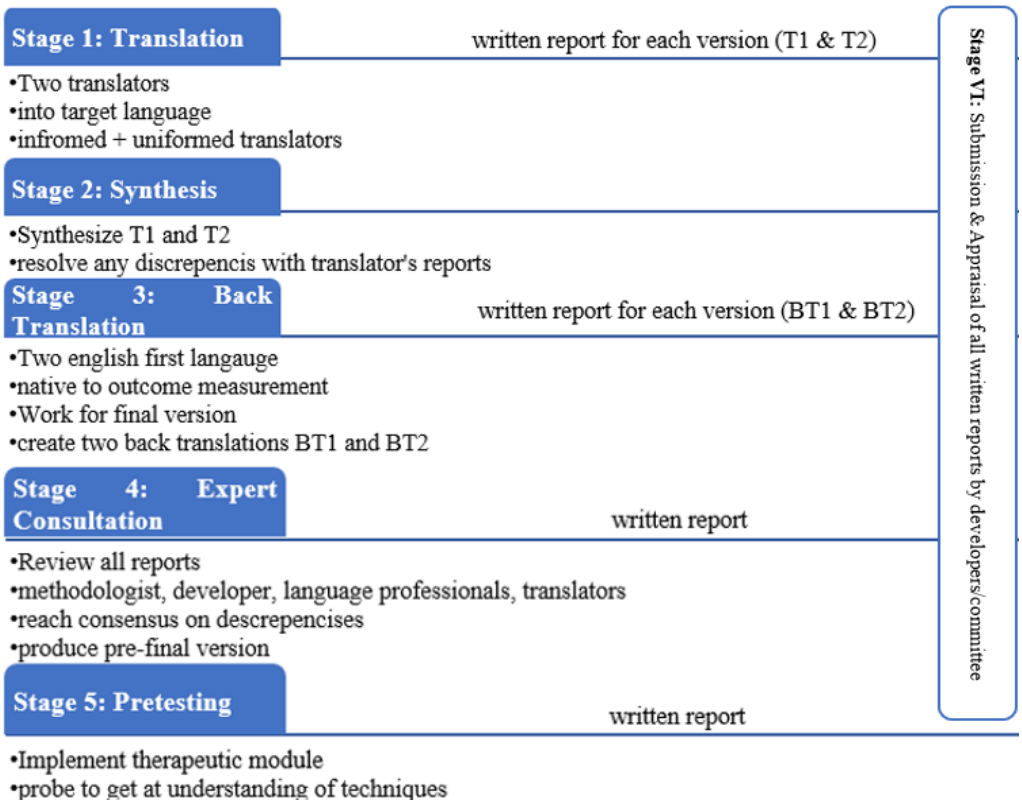

Figure-1: Stages of Translation Back Translation Model of the Present Study

The initial stage of the adaptation process is known as forward translation. We translate the therapeutic module into the target language at least twice from the original (source) language. This process enables the identification of discrepancies between translations, which may indicate linguistic ambiguity in the original text or changes in the translation approach. The translators cast their votes during the discussion about which phrase options they considered to be of lower quality. It is most effective when the translators have therapeutic backgrounds and expertise and fulfil the following eligibility criteria.

(a) Being doctoral candidates in specific therapeutic field; (b) being bilingual in both Native and English language; (c) having therapeutic experience with diverse population; and (d) having translation experience, particularly in native translation. Bilingual translators produce two different versions using their native language as the target language. Translating into one's original language enables a more accurate presentation of language nuances.[5] It is the responsibility of every translator to produce a report detailing their work as a translator. The written report provides detailed explanations for the decisions. The translation includes not only the module text but also the worksheets and instructions.

As the two translators combine their material, an observer records the proceedings. Researchers synthesize these translations using the original module and the versions provided by the first and second translators (T1 and T2) before producing a unified translation. A written report is helpful to learn all about the synthesis method, including the challenges that translators faced and how they overcame them. It is essential to reach a consensus when resolving conflicts, rather than letting one person bottle up their emotions. The therapeutic module, in its second-to-last, final form, completes the following phase.

The translators then return the therapeutic module to its original language. The translator works on the final pre-version without knowing anything about the source material. The goal of this validation is to make sure the translated version is a true representation of the original module's content. Such as, there is a current trend to use terminology that is difficult to understand while translating. There is no assurance of a high-quality forward translation because of the possibility of mistakes, even though there is consistency in the translation due to the agreement between the back translation and the original source version. However, developers and researchers can use back translation to fix any evident inconsistencies or conceptual errors in a translation. A minimum of two back-translations is recommended. Two individuals, fluent in both the source language and native English, completed the back-translations (BT1, BT2). It is an ideal situation when both translators are completely familiar with the topics under review and has background in therapeutic practice. Literature showed that avoiding information bias and discovering unexpected interpretations in the final version of the translated work is important in improving the probability of finding errors.[6,11]

The cultural equivalency goal depends on the committee's foundation. The expert committee consisted on the small but powerful group includes language experts, researchers, methodologists, and experienced interpreters (in both ways). Along with this, there is constant communication between the expert committee and the people who developed the original module. Every version of the module translated by the translators, including the final therapeutic module ready for the therapeutic evaluation, undergoes a systematic compilation by the expert committee. Therefore, following a comprehensive evaluation of all translations, the committee will write down all discrepancies. The committee received the original module as well as its final pre-versions in both the source language and English, including translations (BT1, BT2).

Moreover, the committee also received written reports explaining all the decisions made in the previous steps. Furthermore, module developers expected from the expert group to provide comprehensive written documentation that explains all factors examined and the logic behind any decisions reached. Moreover, the expert committee must make decisions on four different aspects in order to align the source and target versions. In regard to the following four aspects, the context is very important: Do the ideas have definitions that are completely different and cannot coexist? Can something be reconsidered in the module? Does the translation contain any grammatical errors? Is the translation appropriate with regard to equivalence?

In regard to equivalence, it also has been seen that conceptual definitions of words show cultural changes.[12] Thus, activities that closely resemble and are frequently practiced in the target culture should be replaced with those presented in a proposed therapeutic module. For example, if you have trouble getting up after dancing, then the proposed technique in the module might help you. It's seeming like that the country in which you want to implement the module doesn't use dance activities in its culture; however, uniform equity is important. Depending on the culture, the practice of "visiting your relatives to the extent you desire" varies in regularity. This is due to the fact that cultural norms on the characteristics that differentiate an extended family from a nuclear family vary.

Accordingly, a comparison of the original therapeutic module and back-translated versions is necessary for the committee to reach a conclusion regarding their equivalents. Before proceeding, both parties must reach an agreement; if necessary, they can

use translation and back-translation to establish multiple expressions for each subject. Given the ease of establishing such projects, it would be beneficial for the committee to include all translators. In this scenario, a comprehensive evaluation of easily understandable methods, criteria, and solutions is necessary. However, it is also the responsibility of the module's developers and translators to ensure that the intended audience can understand the final therapeutic module.

During the adaptation and translation phase, the pretest concludes. This field test will involve the participation of patients or participants from the intended location in order to evaluate the final version of the new therapeutic module. A sample size of 10–20 individuals is ideal for the testing, although it depends on the number of participants according to a specific therapeutic module. After completing the module's activities and tasks, the next step is to interview the patients to gain insight into the intended purpose of the activities or procedures and their preferences for specific solutions. Proving the relevance of the responses and activities is important. By doing this, the revised version will maintain its coherence when applied to real-world scenarios.

When adapting and translating a therapeutic module, the final step is to provide all relevant documentation and reports to the group responsible for the translated version, or the individual who developed it. They can then confirm that all necessary steps have been completed and that the generated reports are accurate in relation to the methodology. The procedure can be considered an audit of the process based on the reports produced and the guidelines followed. Following this process, the developers of the module can get a translation that makes sense, but they can't change the text as a group.

RESULTS

This study provided a comprehensive analysis of the process of adaptation and translation of therapeutic modules. Maintaining the module's validity and reliability when translating it from one language to another is the goal of cross-cultural adaptation and translation. The produced version must be valid and reliable in the same way as the original. However, this isn't always the case, possibly due to refined cultural variations in how people go about their daily lives, which may add or subtract complexity to some tasks.[13] These changes could compromise the accuracy and reliability of the module.

After the translation and adaptation procedure, the researchers should conduct tests to ensure the new version meets the requirements for the intended application.[14,15] Not only should the new module incorporate the traits already present at the task and score levels, but it should also add responsiveness, content validity, and reliability. In the final step, the module developer must thoroughly evaluate three critical aspects: respondent validity, reliability, and content validity. The module developers can also look at similar tests conducted within the original module's context. Developers of the module anticipate that the enhanced version will deliver comparable results.

DISCUSSION

This article provided step-by-step guidelines for the translation-back-translation model for adapting and translating therapeutic modules. It also demonstrated that an insufficient translation method could result in a therapeutic module that differs from the original. This article discussed a detailed approach to adapting and translating a module to a novel context. In addition, this article also provided guidelines for testing the reliability and validity of therapeutic modules; however, developers must introduce the new module to ensure the system's validity and reliability. The International Society for Quality-of-Life Assessment (IQOLA) guidelines are consistent with the current study's guidelines and their formal testing suggestions for the final module.[2,11]

Moreover, this article provided a conceptual framework model for five-stage steps that involve adapting and translating to a new culture while simultaneously lowering or replacing certain activities as necessary. Translations at the task or activity level assume that the translated tasks adequately represent the concept of health in a different culture, which researchers should take into consideration. However, a previous study[3] aligns with task equivalency as one of several aspects that require consideration. It is important to understand that a translation cannot be considered a precise measure of a culture's liveliness. Thorough verification is important before and during the final testing phase.[16,17] When working with modules that do not have a specific location for translated versions, it is important to follow the steps provided in this article.

This article also discussed some recommendations for future studies. With the right documentation outlining the adaptation and translation process and the final version of the therapeutic module, the developers may avoid the distribution of several translations and, more importantly, the unnecessary complications of all that hard work. Modifying a therapy module for use in a different setting requires effort and time. Therefore, it is important to consider establishing eligibility criteria for translators in various cross-cultural situations. Additionally, this article discussed the strengths of the adaptation and translation process, which is considered the most effective method for obtaining a uniform value across all report data characteristics. Standardised data collection across cultures makes cross-cultural research more accurate

and prevents studies from unfairly eliminating participants who, for whatever reason, are unable to fill out an English form because there is no translated module available.

CONCLUSION

To conclude, the cross-cultural adaptation and translation of therapeutic modules is important to ensure the applicability, reliability, and resonance across diverse populations. By adhering to rigorous processes such as the translation-back-translation model and engaging experts, the language and culture were preserved. This enhances inclusivity in healthcare and ensures that interventions meet both linguistic and cultural needs effectively. In addition, these guidelines embrace cultural sensitivity, linguistic accuracy, and collaborative approaches; practitioners can bridge cultural gaps and promote the delivery of effective mental health care globally. It is also essential to understand the importance of context, involve developers and translators, and use strict validation methods to make therapeutic modules more useful and acceptable in different cultural settings.

AUTHORS' CONTRIBUTION

TQ: Literature search, write-up. NI: Proof reading, review.

REFERENCES

1. Ahmed, S., Malik, T. A., & Naveed, A. (2020). Adaptation and Concurrent Validity of Screen for Children Anxiety Related Emotional Disorders (SCARED). *NUST Journal of Social Sciences and Humanities.* 6. 29-43.
2. Day, S., Laver, K., Jeon, Y., Radford, K., & Low, L. (2023). Frameworks for cultural adaptation of psychosocial interventions: A systematic review with narrative synthesis. *Dementia*, *22*(8). https://doi.org/10.1177/14713012231192360
3. Koç, V., & Kafa, G. (2019). Cross-Cultural Research on Psychotherapy: The Need for a Change. *Journal of Cross-Cultural Psychology*, *50*(1), 100–115. https://doi.org/10.1177/0022022118806577
4. Hendriks, T., & Graafsma, T. (2019). Guidelines for the cultural adaptation of positive psychology interventions. *Caribbean Journal of Psychology*, *11*(1), 7–32. https://research.tilburguniversity.edu/en/publications/guidelines-for-the-cultural-adaptation-of-positive-psychology-int
5. Pestoff, R., Henrik Danielsson, McAllister, M., Johansson, P., & Gunnarsson, C. (2024). Translation, cross-cultural adaptation, and preliminary validation of a patient-reported outcome measure for genetic counselling outcomes in Sweden. *Journal of Genetic Counselling*. https://doi.org/10.1002/jgc4.1896
6. Khan, A., Malik, T.A., Ahmed, S. et al. (2020). Translation, Adaptation and Implementation of Coping Cat Program with Pakistani Children. Child Youth Care Forum 49, 23–41. https://doi.org/10.1007/s10566-019-09516-6
7. Guillemin, F., Bombardier, C., & Beaton, D. (1993). Cross-cultural adaptation of health-related quality of life measures: literature review and proposed guidelines. *Journal of clinical epidemiology*, *46*(12), 1417–1432. https://doi.org/10.1016/0895-4356(93)90142-n
8. Muñoz-Cabello, P., García-Miñaúr, S., Espinel-Vallejo, M. E., Fernández-Franco, L., Stephens, A., Santos-Simarro, F., Lapunzina-Badía, P., & McAllister, M. (2018). Translation and Cross-Cultural Adaptation with Preliminary Validation of GCOS-24 for Use in Spain. *Journal of genetic counseling*, *27*(3), 732–743. https://doi.org/10.1007/s10897-017-0154-z
9. Bullinger, M., Alonso, J., Apolone, G., Leplège, A., Sullivan, M., Wood-Dauphinee, S., Gandek, B., Wagner, A., Aaronson, N., Bech, P., Fukuhara, S., Kaasa, S., & Ware, J. E., Jr. (1998). Translating health status questionnaires and evaluating their quality: the IQOLA Project approach. International Quality of Life Assessment. *Journal of Clinical Epidemiology*, *51*(11), 913–923. https://doi.org/10.1016/s0895-4356(98)00082-1
10. Brislin, R. W. (1970). Back-Translation for Cross-Cultural Research. *Journal of Cross-Cultural Psychology*, *1*(3), 185–216.
11. Gandek, B., & Ware, J. E., Jr (1998). Methods for validating and norming translations of health status questionnaires: the IQOLA Project approach. International Quality of Life Assessment. *Journal of clinical epidemiology*, *51*(11), 953–959. https://doi.org/10.1016/s0895-4356(98)00086-9
12. Wild, D., Grove, A., Martin, M., Eremenco, S., McElroy, S., Verjee-Lorenz, A., Erikson, P., & ISPOR Task Force for Translation and Cultural Adaptation. (2005). Principles of Good Practice for the Translation and Cultural Adaptation Process for Patient-Reported Outcomes (PRO) Measures: report of the ISPOR Task Force for Translation and Cultural Adaptation. *Value in health: the journal of the International Society for Pharmacoeconomics and Outcomes Research*, *8*(2), 94–104. https://doi.org/10.1111/j.1524-4733.2005.04054.x
13. Kirmayer L. J. (2012). Cultural competence and evidence-based practice in mental health: epistemic communities and the politics of pluralism. *Social science & medicine (1982)*, *75*(2), 249–256. https://doi.org/10.1016/j.socscimed.2012.03.018
14. Binkley, J., & Koslofsky, S. (2017). Una Familia Unida: Cultural Adaptation of Family-Based Therapy for Bulimia with a Depressed Latina Adolescent. *Clinical Case Studies*, 16(1), 25-41. https://doi.org/10.1177/1534650116668268
15. Ware, J. E., Jr, & Gandek, B. (1998). Methods for testing data quality, scaling assumptions, and reliability: the IQOLA Project approach. International Quality of Life Assessment. *Journal of clinical epidemiology*, *51*(11), 945–952. https://doi.org/10.1016/s0895-4356(98)00085-7
16. Rathod, S. (2017). Contemporary psychotherapy and cultural adaptations. *Journal of Contemporary Psychotherapy: On the Cutting Edge of Modern Developments in Psychotherapy, 47*(2), 61–63. https://doi.org/10.1007/s10879-016-9344-5
17. Kirkpatrick P, van Teijlingen E. Lost in translation: reflecting on a model to reduce translation and interpretation bias. Open Nurs J. 2009 Jun 23; 3:25-32. doi: 10.2174/1874434600903010025

Submitted: July 12, 2024	*Revised: September 10, 2024*	*Accepted: October 9, 2024*

Address for Correspondence:

Tania Qamar, Doctoral Candidate, School of Applied Psychology Social Work & Policy, University Utara-Malaysia
Tel: +601175332308
Email: tania_qamar@ahgs.uum.edu.my