

DEVELOPMENT AND VALIDATION OF AN INDIGENOUS URDU SCALE FOR MEASURING PERCEIVED MENTAL HEALTH STIGMA AMONG YOUNG ADULTS IN PAKISTAN

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Abstract

The aim of the current research was to determine the content validity of an indigenous mental health stigma scale in Urdu among young adults in Pakistan. The main aim was to come up with a culturally sensitive instrument that fully reflects the multidimensionality of mental health stigma in this group of people. The scale was developed and validated in four consecutive phases, as follows: (1) item generation and original scale construction, (2) qualitative expert reviews, (3) quantitative content validity testing and (4) reliability testing. A panel of six subject-matter experts was chosen using a convenience sampling technique to perform content validation. The panel included experts who had been proven to have expertise in mental health service. The content validity methodology of Lynn (1986) was applied in order to study inter-rater agreement. The pre-test scale contained 33 questions measuring the personal stigma on cognitive, behavioral and knowledge based levels. An item-level agreement value of 0.50 was set as a minimum, sixteen items were dropped and a highly relevant and understandable instrument was obtained. This scale is the first empirically constructed Urdu-language perceived mental health stigma scale. The results suggest preliminary support of the content validity of the instrument and the basis of a further study on the factor structure, reliability, and construct validity of the instrument.

Keywords: Mental Health Stigma; young adults; validation study, psychometric evaluation, young adults.

1. Introduction

In nearly all cultures, the research proves that one of the greatest barriers to psychological assistance is the mental health stigma. According to Corrigan (2004), it is more than a negative attitude in seeking psychological help, a process that is destructive and stereotyping, which leads to the ultimate discrimination. This is normally translated to social rejection or exclusion of individual persons with mental health problems. Adopting these social biases, the individuals begin to feel self-stigma that damages their self-esteem and makes them even more unwilling to accept professional assistance (Corrigan and Watson, 2002). Also incredibly when there is progressive enhancement of social and educational system within the area, mental health stigma remains intact in Pakistan. The fear of being judged in some instances because of the confidentiality factor makes most people not seek help because they are pressurized to align to some social norms (Link et al., 2004). The mental health care and its access in the country are incredibly uneven due to the absence of professionals in the sphere (Javed et al., 2020). Such issues are normally exacerbated by the media that works on exaggerated or harmful stereotypes is also a fear and misguided perception of individuals with mental health problems (Scott and Chur-Hansen, 2008). A general mental health illiteracy is one of the main factors that cause the issue. The number of people that do not have adequate information on causes or symptoms of mental illness is very many. Hence, a phenomenon of supernaturalism tends to define mental illness, (Husain et al., 2020). The role of religious and cultural values is significant in this situation, e.g. psychological distress can be seen as a test of God (ibtilah), a punishment when a sin is committed or the presence of the spirit, e.g. jinn (Naeem et al., 2015). These beliefs, on their part, are the factors that prompt the families to prefer spiritual or religious treatment to clinical care. The collectivist nature of the Pakistani society also propagates this stigma. The honor of the family (izzat) is prioritized over mental illness diagnosis and the diagnosis of the mental illness is commonly viewed as a shame issue to the family and to the individual (Saeed et al., 2019). The fear causes a large proportion of young adults to live in silence particularly when they fear that their condition will ruin their future lives. Stereotypes which remain constant such as lack of mental health literacy leads to social exclusion of the persons with mental health problems (Pescosolido et al., 2013). More gender roles complexity. The demands of endurance and strength set

upon men mean that they cannot admit that they have emotional problems because this may be understood as an expression of masculinity weakness that does not favor the admission of help (H. Khan et al., 2020). In women, the stigma is typically tied up to the social status and the respect of the family which restricts the access to care to a great extent. However, despite this inculcated problem, some headway is being achieved on reducing stigmatization of mental health by improving mental health literacy. It is also evidenced that the interventions that are founded on the culture that is growing up within the community have been shown to be the most effective because of reasons such as the incorporation of mental health education in the religious teaching context and the engagement of imams or scholars have been shown to be effective in enhancing the acceptance levels and reducing the levels of stigma of mental issues among the Muslim populations (Gearing et al., 2013). Community awareness and digital media are also turning out to be helpful in the education of the population (M. N. Khan and Chiumento, 2016). However, there are long-term transformations related to the policy changes in advocacy to implement mental health literacy as a subset of primary care and improvements of anti-discrimination legislation. Still, mental health stigma in Pakistan is a multi-year endeavor, which is supposed to be tackled with the assistance of a culturally-based approach. Interventions ought to improve literacy, family and community leaders, stereotyping and systemic barriers in order to bring a substantial change. Thus the stigma of mental health is only something that can be stratified through a concerted action in all levels of the society.

2. Materials and Methods

Method

Design

The Standards framework was an approach to methodological content validity study. The research took four steps of content validation; item development, reliability and clarity test, expert test and qualitative feedback.

Item Development

The items in the scale were created in a deductive manner using Corrigan progressive model of self stigma and the available stigma and self stigma scales (e.g. Docksey, Gray, Davies, Simkiss, and Snowden, 2022), and the existing empirical literature on the topic of mental health stigma. Design of items was based on the dimensions of public stigma and self stigma and this was the stigma perception, behavior and knowledge. The statements were drafted in simple and affirmative wording, which was not ambiguous and based on the experiences of the young adults within the Pakistani culture. Assessment of Reliability and Clarity. Everything was checked on clarity, simplicity and accessibility. Language was also verified to make sure it is easy to understand and also to reduce ambiguity, the grammatical consistency and length of sentence were kept in consideration.

Expert Evaluation

Convenience sampling was utilized to recruit six mental health professionals who work in Lahore institutions. The judges rated the items (judged as not relevant) on a four point scale (1 = not relevant, 4 = highly relevant) after informed verbal consent on the following scale: clarity (ease of understanding) and relevance (representation of stigma dimensions). Content validity was offered quantitatively by ratings.

Qualitative Feedback

Besides the numerical ratings, judges also made qualitative remarks on item wording, cultural appropriateness and construct representation. This feedback was evaluated pragmatically and was applied to perfect items, so that they fit the theoretical constructs and cultural context.

Instrument

The pretested tool included 33 questions that evaluated mental health stigma in the Pakistani culture. They were created to be used when no one is present, alluding to the context and experiences of the respondents and targeted a variety of dimensions of stigma in an all-encompassing manner.

Sample

The current research utilized a convenience sampling method in order to reach out subject matter experts to validate the content. Six subject-matter experts (N = 6) were requested to participate because of their experience

in the areas of mental health, clinical psychology, and psychometric evaluation.

The inclusion criteria of expert selection were:

- Minimum eligibility of MS/MPhil or equivalent in Psychology or any other related subject.
- Mental health services or academic experience as a professional.
- Scale development or validation processes familiarity.

The convenience sampling was deemed suitable at this stage because verification of the content of the tested experiment is not a matter of general representation but that of an expert. The sample size chosen was in line with the recommendations made by Lynn (1986) who points out that a panel of 5-10 experts is adequate in determining Content Validity Index (CVI).

Demographic Characteristics of Experts

Variable	Category	Frequency (f)	Percentage (%)
Gender	Male	3	50%
	Female	3	50%
Qualification	MS/MPhil Psychology	4	66.7%
	PhD Psychology	2	33.3%
Professional Role	Clinical Psychologist	3	50%
	Lecturer/Academic	3	50%
Experience	1–5 years	2	33.3%
	6–10 years	3	50%
	10+ years	1	16.7%
Location	Lahore-based Institutions	6	100%

Data Analysis

The CVI indices following Lynn (1986) I-CVI (item-level content validity index) The proportion of content experts giving item a relevance rating of 3 or 4 $I-CVI = (\text{agreed item}) / (\text{number of expert})$ S-CVI/Ave (scale-level content validity index based on the average method) The average of the I-CVI scores for all items on the scale or the average of proportion relevance judged by all experts. The proportion relevant is the average of relevance rating by individual expert. $S-CVI/Ave = (\text{sum of I-CVI scores}) / (\text{number of item})$ S-CVI/Ave = (sum of proportion relevance rating)/(number of expert) S-CVI/UA (scale-level content validity index based on the universal agreement method). The proportion of items on the scale that achieve a relevance scale of 3 or 4 by all experts. Universal agreement (UA) score is given as 1 when the item achieved 100% experts in agreement, otherwise the UA score is given as 0. $S-CVI/UA = (\text{sum of UA scores}) / (\text{number of item})$

Results

	Expert1	Expert2	Expert3	Expert4	Expert5	Expert6	Experts agreement	CVI
No of items								
1.	1	0	1	1	1	1	5	0.833
2.	0	1	0	1	0	1	3	0.5
3.	1	1	1	0	1	1	5	0.833

4.	1	1	0	0	0	1	3	0.5
5.	0	1	0	1	0	1	3	0.5
6.	1	1	0	1	0	1	3	0.5
7.	1	1	0	1	0	1	4	0.66
8.	0	1	1	1	1	1	5	0.833
9.	1	1	1	1	1	1	6	1
10.	1	1	1	1	1	1	6	1
11.	1	1	1	1	1	1	6	1
12.	1	1	1	1	1	1	6	1
13.	1	1	1	1	1	1	6	1
14.	1	1	1	1	1	1	6	1
15.	1	1	1	1	1	1	6	1
16.	0	0	1	1	1	0	3	0.5
17.	1	1	1	1	1	0	5	0.833
18.	0	1	1	1	1	0	4	0.66
19.	0	1	1	1	1	0	4	0.66
20.	0	1	1	1	1	0	4	0.66
21.	0	0	1	1	1	0	4	0.66
22.	1	1	1	1	1	1	6	1
23.	1	1	1	1	1	1	6	1
24.	1	1	1	1	1	0	5	0.833
25.	1	0	1	1	1	1	5	0.833
26.	1	1	1	1	1	1	6	1
27.	1	0	1	1	1	1	5	0.833
28.	0	1	1	1	1	0	4	0.66
29.	1	1	1	1	1	1	5	0.833
30.	1	0	1	1	1	0	4	0.66
31.	1	0	1	1	1	1	5	0.833
32.	1	0	1	1	1	1	5	0.833
33.	1	1	1	1	1	1	6	1
Proportion Relevance	0.72	0.75	0.84	0.93	0.84	0.72		26.45

S-CVI/AVE= 0.80

S-CVI/AVE= 0.80

PROPORTION RELEVANT 0.8

17 items on the basis of high CVI out of the 33 initial items were selected for the final scale.

Discussion

The major objective of this research was to create an indigenous Urdu scale related to perceived mental health stigma among young adults in Pakistan. Taking into account the socio-cultural peculiarity of stigma, the research aimed at developing a culturally sensitive measure that is based on local beliefs, practices, and social norms. Mental health stigma is one of the most high order impediments to help-seeking behavior, anywhere across the world, and its expressions are heavily influenced by cultural, religious and social forces. The phenomenon of stigma in collectivist cultures like Pakistan is not just an individual one; it is deeply rooted in the family systems, in the community laws, and in the religion (Husain et al., 2021). Lack of psychometrically good instruments with cultural basis has in the past been a set back to measurement and understanding of perceived stigma towards mental health in Pakistani setting. Development of this indigenous scale addresses the said gap by creating a tool that is linguistically competent, contextually appropriate.

The results show that the developed scale has acceptable content validity. The Scale-Level Content Validity Index (S-CVI/Ave) was equal to 0.80, which is the lowest acceptable index, according to Lynn (1986), and which indicates that the scale items as a group measure the construct of perceived mental health stigma. On an item level, items 9 to 15, 22, 23, 26, and 33 used at the item level had perfect expert agreement (I-CVI = 1.00), indicating a high-level of agreement on its relevance and clarity. Those products that had lower I-CVI (0.50) were dropped to narrow down the measure to a small 17-item scale. The proportion relevance ratings collected among the experts were between 0.72 and 0.93 which once again proved the sufficiency of the content validity of the scale. All these findings substantiate the hypothesis that the scale in its 17-item version is content-adequate to satisfy the basic psychometric standards. It is important to note that the fact that high I-CVI values are achieved by a combination of multiple items indicates the experts were not only in agreement as to what the scale was to measure, but also the degree to which the specific items used in the scale are appropriate in measuring the construct. Such inter-rater reliability, especially within a panel with varied professional backgrounds, gives some level of credibility to the basis of the instrument and therefore, necessitates psychometric testing with factor analysis and reliability tests.

The expert panel was made up of an equal gender representation (50% male and 50% female), professional occupations such as clinical psychologists and academicians and with qualifications of MS/Mphil and PhD. The majority of the experts were with 6-10 years of work experience, which guaranteed enough domain background. The panel was also diverse especially in having both clinicians and academics and this increased the credibility of the validation process (Polit and Beck, 2006). The practical frontline understanding of the way stigma occurs among patient groups by clinicians is complemented by the theoretical rigor and methodological expertise provided by academics, which enhances the ecological and construct validity of the instrument. Nevertheless, due to a high concentration of experts in Lahore, there is potential limitation of geographical generalizability. Pakistan is a culturally and linguistically diverse country and there is a significant regional disparity in the attitudes to mental health and level of access to psychiatric services. The attitude of urban centres like Lahore might be more modernized or westernized than rural or semi-urban centres. Such geographical concentration of the expert panel is one of the recognized shortcomings that must be overcome by the validation studies of the future as it should be ensured that the instrument would capture the diversity of cultural manifestation of stigma throughout the country.

The S-CVI/Ave of 0.80 demonstrates that the scale has satisfactory content validity as the recommendation provided by Lynn (1986) suggests that a scale should be assessed by 5-10 experts. This is commonly considered as a sign of a well represented domain of content, but not as high as the 0.90 level occasionally used in highly specialised clinical scenarios (Polit & Beck, 2006). The achievement of this value is specifically important considering that perceived mental health stigma is complex and multidimensional, and it has cognitive, affective, and behavioral elements that are differently manifested in different cultural contexts. Those items with I-CVI = 1.00 are probably the prime dimensions of perceived mental health stigma such as negative beliefs, discriminatory attitudes and awareness. These results align with previous studies regarding the subject of mental health stigma in Pakistan that have placed emphasis on the existent socially and culturally internalized stigmatizing attitudes among the young adults (Husain et al., 2021; Malik and Irfan, 2019). Expert

agreement is high on these items suggesting their relevance in concept and linguistic accessibility and hence should be included in the final scale.

It is necessary to communicate that content validity, as a fundamental one, is only the initial step in scale validation. Additional research ought to be done in this contribution by investigating criterion validity by both convergent and discriminant analysis, and predictive validity by determining the scale capacity to predict help-seeking behavior or subjective distress in both clinical and community samples. In the absence of these supplementary types of evidence, we are unable to ascertain the applicability of the scale in a variety of real-life contexts. About 17 of the 33 items were dropped because of low I-CVI ($= \text{or} = -0.50$), items 2, 4, 5, 6, and 16. This logical improvement is in line with the best practices in psychometric development, which values parsimony and clarity (DeVellis, 2017). This involves the use of the item reduction process which is based on objective CVI thresholds as opposed to subjective judgment in developing the scale, is an example of a methodologically transparent way of scale development. Everything that was taken off did not probably pass the test of expert consensus because of vague formulation, irrelevance to other cultures, or self-duplication with other higher performance items. The scale is practical and feasible as it is short with only 17 items that minimize fatigue and respondent burden and enhance the accuracy of the responses. In scale development, other studies in South Asia have also highlighted the significance of succinct instruments in ensuring the participation of the participants and proper measurement (Kohrt et al., 2014). This especially applies to the Pakistani setting, where potentially low mental health literacy rates and an overall lack of familiarity with psychometric assessment instruments may predetermine a tendency towards acquiescence bias or unresponsive responding in case instruments are too long. In addition, the process of intentional downsizing to 17 items does not always mean that they lost theoretical breadth. As long as the retained items indicate a wide sample of the domain of stigma, including public stigma, self-stigma, institutional stigma and structural barriers to help-seeking, the scale is able to cover construct coverage and be pragmatically short. Further analyses of the theoretical adequacy of the item pool may be done using exploratory and confirmatory factor analysis to define the format of dimensional structure of the construct underlying.

One of the strengths of this study is that the scale is culturally grounded. Pakistan has a rich history of perceived mental health stigma, which is closely associated with socio-cultural and religious ideologies of the nation, such as supernatural causes (e.g., jinn possession), family honor (izzat), and gendered roles (Husain et al., 2021; Malik and Irfan, 2019). These culturally particular manifestations of stigma are not just marginal variations on Western forms of meaning but are, essentially, different systems of meaning by which psychological distress is made sense of, expressed and acted upon. The inclusion of professional qualitative feedback was such that these culturally specific dimensions were sufficiently represented in the items and this improved ecological validity. It responds to one of the major shortcomings of scales that are developed in the West as they tend to miss out on the local specifics and overestimate the culturally specific types of stigma (Kohrt et al., 2014). Depression Stigma Scale (Griffiths et al., 2004) or the Attribution Questionnaire (Corrigan et al., 2003) are examples of instruments that, although psychometrically sound in their respective contexts, were created in individualistic and mostly secular societies. Their direct adjustment without cultural adaptation threatens to create inequivalence as items can have varying cognitive schemas or have varying connotative meanings in diverse cultural contexts. The explicit inclusion of Islamic idioms of distress, and family-based conceptualizations of stigma in the existing scale is a non-insignificant methodological addition to cross-cultural psychometrics. This paper is part of the current decolonizing movements within the field of psychology, where ethnically relevant and ethnically tested assessment methods are promoted by placing the tool in the context of local categories of experience (Arnett, 2008; Fernando, 2014). The potential of combining both quantitative indices (CVI) of content validity and qualitative expert feedback is a rigorous mixed methodology, which is encouraged in the published literature on the development of scales (Polit and Beck, 2006). Whereas CVI gave a certain objective level of relevance to items, qualitative input enabled the refinement of the wording, appropriateness to specific cultures, and clarity of concepts. The triangulation of the methods is especially crucial in situations of stigma measurement, in which even minor variations in wording, including using colloquial and formal Urdu, can greatly influence the way of interpreting the items and the response patterns.

The fact that both quantitative and qualitative results are convergent enhances the effective use of the scale in terms of its validity and indicates significant relevance of putting psychometric tools in context of the

socio-cultural realities of targeted population. Brief remarks on the wording of items by experts also helped in identifying culturally loaded words that even though they statistically worked well, they had unintended implications on some members of the demographic. This process of reflection and improvement can be seen as a reflection of the most successful practices provided in the Standards of Educational and Psychological Testing (American Educational Research Association, 2014), which specifically supports the use of expert judgment in tandem with empirical data during the creation of valid instruments. Additionally, it is apparent that the mixed-method approach places the study in a good position among the wider scope of the studies of indigenous psychology in South Asia. The qualitative aspect made sure that the scale was not just an exercise in translation, but a real conceptual re-creation of stigma measure under the Pakistani epistemological system. Future research can also build on this base by carrying out cognitive interviewing of the target respondents to determine the level of understanding of the items used and any cultural dissonance that still exists at the level of a community. In theory, the current study will add to the expanding literature of proponents of culturally pluralistic conceptions of mental health stigma. The research questions the implicit universalism of mainstream stigma theories by showing that the construct of perceived stigma can be operationalized by using indigenous Urdu items and suggests that the cultural specifics mediate the experience, expression and effects of stigma. The establishment of this scale provides a base on which the research can be done in the future to examine the relationship between stigma and religion, gender, socioeconomic status, and generational differences in the Pakistani society.

Although it is not yet feasible practically, it is important to note that the 17-item Urdu scale will be a timely and valuable tool to mental health professionals in Pakistan. The scale may serve as a screening instrument to help clinicians understand that the high levels of perceived stigma in the individuals mean that they are on the verge of postponing or evading the process of seeking psychiatric assistance. The scale can be used to monitor the baseline level of stigma and evaluate the effectiveness of a program in reducing mental health stigma by the use of public health programs to reduce this stigma through community awareness campaigns, education in schools, and media interventions. The linguistic friendliness and brevity of the scale especially best suited it to large-scale epidemiological survey and community-based study. 5.6 Strengths and Limitations The current paper has a number of strengths. First, indigenous development approach makes it culturally relevant and linguistically accurate making this tool unlike Western translated instruments. Secondly, methodological rigor (as a mixed-method validation framework, i.e., CVI with qualitative expert feedback) is quite rare in the development of stigma scales in the context of Pakistan. Third, the representativeness of the validation process could be elevated through the diversity of the expert panel, which includes both academic and clinical expertise and gender balance. However, there are a number of constraints that should be considered. The regional homogeneity of the validation process described by the physical proximity of specialists in Lahore may fail to reflect the diversity of the stigma-related attitudes in Pakistan. Also, the current research is not completely valid other than content validity since construct validity, criterion validity, and reliability remain unprovable. Lack of pilot administration with the target population implies that items level psychometric properties (including item discrimination, and internal consistency) are unknown. Lastly, the scale is not yet justified against any other stigma measures or other similar constructs, so we can not draw definitive conclusions about convergent and discriminant validity.

Directions for Future Research

There are some areas that should be approached in the future research. To test the factors structure, internal consistency and test-retest reliability of the scale, first, a high-scale pilot study involving a mixed-breed sample of young adults, both urban and rural areas, in Pakistan should be done. Structural equation: The exploratory factor analysis (EFA) and confirmatory factor analysis (CFA) would assist in defining the dimensional makeup of the scale and ensure that it is consistent with the theoretical model of perceived stigma. Second, the scale would be clinically useful with studies on the predictive validity of the scale in respect of help-seeking behavior, self-stigma, and mental health outcomes. Third, the research on cross-cultural adaptation, e.g. to regional dialect, like Sindhi, Pashto, or Punjabi, would help to broaden the scale and compare it across ethnic groups in Pakistan. Lastly, longitudinal studies that use this scale may give information about the time varying perceived stigma in relation to the change in the society, mental health campaigns, and policy interventions. 5.8

Conclusion

This research is an important methodological contribution to the measurement of mental health stigma in Pakistan in the sense that it has developed and content-validated an indigenous Urdu scale that is specific to the socio-cultural reality of young adults. The 17-item measure has sufficient content validity, expert unanimity and cultural sensitivity, which makes it an attractive research and clinical instrument. Although constraints in terms of geographic representation and initial validation phase are admittedly present, the research provides a very strict ground on which the future psychometric development may be built. Mental health stigma hinders the process of seeking care and causing suffering to an individual in a national context, and therefore, such a tool as the one created during this study is not a mere academic artifact but a valuable practical and social tool. By quantifying what communities are in fact experiencing - using their own words and through their own cultural prism - researchers and clinicians will be better equipped to comprehend, treat and eventually mitigate the stigma that remains one of the biggest barriers to mental health equity in Pakistan.

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