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Translation and Adaptation of Simplifying Mental Illness plus Life Enhancement Skills (SMILES) Program.

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The current study aimed at translation and adaptation of Simplifying Mental Illness plus Life Enhancement Skills (SMILES) Program. It comprised of two phases: phase I was the translation and adaptation of SMILES Program, and Phase II was the pilot testing of the program. Translation and adaptation of SMILES Program comprised of six steps. Step I was forward translation of SMILES Program. Step II was the adaptation of SMILES Program. Step III was about determining the appropriateness of the adapted material with the consultation of experts and parents. In step IV Urdu translated material was analyzed by experts in ten committee meetings. Step V was the back translation of the SMILES Program. After receiving the back translations, the conceptual and linguistic equivalence between the back translated and the original SMILES Program was established in Step VI by following the committee approach. After adaptation of the entire program, it was pilot tested on a sample of ten offspring (children and adolescents) of depressed parents. Diagnosed depressed parents were taken from different hospitals; the diagnosis was reconfirmed by administering Siddiqui Shah Depression Scale (Siddiqui & Shah, 1997). Parents had to rate their children on Child Problem Checklist (Tariq & Hanif, 2007). Knowledge questionnaire and Life Skill Questionnaire were filled by children themselves. Results showed that all scales were quite reliable. High positive correlation was found between original, forward translated (Urdu) and backward translated (English) versions of Knowledge Questionnaire (KQ) and Life Skill Questionnaire (LSQ). It was also evident that parental depression was positively correlated with behavioral problems of their children.

Keywords: Parental depression, behavioral problems, Simplifying Mental Illness plus Life Enhancement Skills (SMILES), Translation, Adaptation.

Parents are main pillars of a family system (Doherty, 2000). When the parents are mentally ill the whole system may collapse. One of the common parental mental illness is depression, which have severe and long-term effects on a child's growth. Patel et al. (2007) recognized four mental health problems (viz., schizophrenia, depression, alcohol abuse, and developmental disabilities) for which adults and children are more at risk. The effects of parental depression are not only restricted to infancy, but it also has its consequences in toddler hood, preschool age and school age kids. Children of depressed parents are at risk for developmental and behavioral difficulties and also at risk for developing depressive disorders. Some parents may have extra possibility to experience depression and recurrence of depression (Kessler et al., 2005).

Families having a depressed parent may lead to disruption in parenting (Hammen & Brennan, 2001). Parental depression has been linked with emotional and behavioral disturbances both in community and in clinical populations, among children and adolescents (National Research Council [NRC] & Institute of Medicine [IOM], 2009). The research work documenting the impact is somewhat consistent—parental depression has been negatively connected with a variety of results among children from early life to teenage years (Goodman & Gotlib, 2002; Jaser et al., 2005). Substantial number of studies indicated that offspring are at increased hazard for internalizing and externalizing difficulties due to parental depression (England & Sim, 2009; Goodman et al., 2011). Depressed parents are involved in disruptive parenting and it leads to traumatic communication between parents and offspring (Howard & Medway, 2004; Brennan, LeBrocque, & Hammen, 2003). Depressed parents are more prone to display withdrawn actions and disturbing behaviors than parents who are not depressed (Jaser et al., 2008). Further, indicators of internalizing and externalizing behaviors in children and adolescents are robustly linked with withdrawn and intrusive parenting behaviors (Jaser et al., 2005). A research by Goodman et al. (2011) established that internalizing, externalizing, common psychopathology; negative emotions and less positive behavior in children and adolescents are associated with mother's depression.

Parental mental health problems and its interaction with adverse outcomes for children have been well argued in western studies (Rutter, 1996; Gopfert, Webster, & Seeman, 1996). Interventions aimed at preventing or reducing behavioral problems is necessary in childhood and early adolescence (Ybrandt, 2008; Copeland, Shanahan, & Costello, 2009). Available resources are very few in number for the treatment of children's psychological problems. These resources are not distributed equally and relevant services are inefficient and incompetent. These are the major obstacles to better mental health services for children, especially in under-developed countries like Pakistan. People with economic insufficiency are in extreme need of mental health care, but they have inadequate access to it, especially children and adolescents with mental disorder cannot approach these resources (Saxana, Throcroft, Knapp, & Whiteford, 2007). Lancet group of Global mental health (2007) identified the lack of resources and treatment plans for mental disorders in under developed and developed states. Coplan (2013) has given a behavior management plan for internalizing behavior of children. It includes staff education, student education, deep breathing, mental imagery, isometric exercises, fidget toys, direct interventions, school intervention, family management, play activities, and cognitive behavioral therapy.

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In Australia, Children of Parents with a Mental Illness (COPMI) organized such effort to develop the intervention plan. The goal of COPMI is to present information about the parents with mental illness to those family members who look after and work with them across Australia. One of the intervention plan proposed by Pitman and Mathey (2004) is "Simplifying Mental Illness plus Life Enhancement Skills (SMILES)." It is one of the most common and effective program to use with children. It is designed to enhance the capability to manage efficiently, self expression, improvement of creativity, lower down the feelings of loneliness and boost up self-esteem. It is achieved by different educational, interaction and life skills activities and exercises (Pitman & Matthey, 2004).

SMILES Program is a three days intervention plan, best for those children whose one or both parents or any of siblings is suffering from mental illness like schizophrenia and depression etc. This plan is particularly intended for group intervention of age ranges 8-12 years or 13-16 but is best with the minimum age range of 8 to maximum of 10 years. In case if group administration is not possible, then many of its activities can be administered with in individual counseling sessions. However, the advantage of working in the group is the shared peer interaction and the interaction with instructor, plus it is time effective.

Sometime it is difficult to develop independent indeginous intervention program due to non avaiability of experts in the field or lack of resources and it is better to translate and adapt already existing programs. Adaptation is cost-effective and quicker than constructing a new intervention. It can be helpful in cross-cultural assessment, and for comparable research plans (Hambleton & Patsula, 1999).

There is a scarcity of mental health services for children in Pakistan. It is a need of time to save the children from depressed family environment to save our future. Provided that children of depressed parents need support, care, and intervention; timely implication of intervention is of crucial importance. Present study was carried out to translate and adapt the SMILES Program for the behavioral problems of children and adolescents in Pakistan, whose parents had depression. The study was planned to achieve the following objectives:

1. To test the relationship between parental depression and children behavioral problems.
2. To translate the SMILES Program.
3. To culturally adapt the SMILES Program.
4. To test the comprehensibility of SMILES Program on children and adolescents.

Method

Sample

Sample was drawn from two set of populations: parents diagnosed with depression and their children for the second phase of the study.

Sample I. A sample of 10 diagnosed depressive parents (mothers=5, fathers=5) was taken from different hospitals of Islamabad and Rawalpindi. Parent's age ranges from 37 to 50 years and education varies from middle to graduation.

Sample II. It consisted of 5 children (girls=3, boys=2) and 5 adolescents (girls=3, boys=2) of above mentioned depressed parents, Age ranges from 8 to 12 years for children and 13 to 16 years for adolescents. All of them were school going and their education level varies from grade three to grade nine. Parents belong to middle class families.

Instruments

Siddiqui Shah Depression Scale (SSDS). Siddiqui Shah Depression Scale (Siddiqui & Shah, 1997) was used to determine parent's depression. It is an indigenous assessment tool for measuring depression. It is a self report instrument comprised of 4 point rating scale. It comprises of 36 items. The alpha coefficients for the clinical and non-clinical samples were .90 and .89, respectively. Its cutoff point is median, those who score above median are severely depressed and below median scorers are mildly depressed (Siddiqui & Shah, 1997).

Child Problem Checklist (CPCL). Child Problem Checklist (Tariq & Hanif, 2007) was used for the detection of behavioral problems. It consists of 80 items. It is for the individuals of age 3-18 years. It consists of three factors, first is, externalizing problems, including 36 items: Second is, internalizing problems, including 33 items: Third factor is, somatic complaints, consisting of 11 items. There are two versions of CPCL, one is parent rating and the other is teacher rating. In the present study parent rating version of CPCL was used. The reliability of the scale is .98 (Tariq & Hanif, 2007).

Translated Simplifying Mental Illness plus Life Enhancement Skills (SMILES) Program (Pitman & Matthey, 2004). It is appropriate for children who have a mentally ill parent, suffering from mental health disorders. It is workable on the group of individuals. It has different exercises like mental illness education, Create a card, Children on a tree, Desiderata, Family drawing, Feelings story, Compliments, Favorite pet/object/person, Friends drawing, 'It's good to be me' game, Ice-breaker - an introductions, Ideal family meditation, Meditation, Inner-view, Outdoors, photograph, pie chart and problem solving (for detail see introduction).

Basic aim of these activities is to encourage the development of creativity, self expression, interaction abilities, communication abilities, and listening abilities, expression of self, self responsiveness, expression of feelings, self understanding and confidence building. It facilitates to relax the body and mind. It improves the problem solving skills and coping ability to make the children more calm and peaceful. It provides an opportunity to find out more about family and to understand the world around them. It helps to identify the good characteristics in others and ourselves. It enhances the ability of observation and sensation like touch, smell, sight, and hearing.

Evaluation of children's knowledge regarding parental depression and life skills are conducted through the following questionnaires:

Knowledge Questionnaire. It is comprises of nine knowledge questions. It is used to measure the children's knowledge regarding parental depression. It is a 5 point rating scale, with 1 as "I know nothing at all" to 5 as "I know everything there is to know". Children have to rate themselves on pre-test, post-test and follow up. At the end children are rated on each statement as to whether they now know more / less / or the same amount since they had joined the SMILES program (Pitman & Matthey, 2004).

Life Skills Questionnaire. It consists of 10 life skill questions. It is a 5 point rating scale, with 1 as "I find it very hard to do", and 5 as "I find it really easy to do". Children rate themselves on pre-test, post-test and follow up. At the end children rate whether he/she be capable for skills to get them harder / easier / or had not changed

over the time span of the SMILES program (Pitman & Matthey, 2004).

Procedure

The study was completed in two phases:

Phase I: Translation and adaptation of SMILES Program. The SMILES Program was adapted for Pakistani families by adaptation guidelines and translation techniques provided by Guillemin, Bombardier and Beaton (1993) and Brislin (1980) respectively. Brislin (1980) suggests that more than one independent translation, back translation and committee approach should be utilized to preserve equivalence between one language and culture and another language and culture. These guidelines (e.g., forward translation, committee approach, backward translation, committee approach, and pilot study) have been utilized in most researches for cultural adaptation of interventions. Parents and fellow professional's feedback was also incorporated during adaptation process. Extensive Literature, other adaptation processes and intervention plans in other parts of the world were reviewed (Crisante & Ng, 2003; Forehand & Kotchick, 1996; Gorman & Balter, 1997; Kumpfer, Pinyuchon, de Melo, & Whiteside, 2008; Lau, 2006).

Phase 1 was completed in six steps:

Step I: Forward translation of SMILES Program. The content includes the assessment and treatment materials. When the concepts presented in a program show incongruity across cultures, it is known as 'construct bias' that should be resolved first. Main technique to adapt and translate the content can be possible by having a team of experts having proficiency in both languages and cultural contexts (Brislim, 1980). Translations for all the assessment and treatment material was done by a 12 member committee having M.Phil degree in Psychology including three clinical Psychologists, five faculty members having masters level teaching experience in developmental Psychopathology, and four doctoral students of Psychology. Translators had good knowledge of the cultural framework and had information of translation rules.

Step II: Adaptation of SMILES Program. Adaptation of SMILES Program led to the replacement and modification of its content according to cultural values. Adaptation committee was consisted of four members, three were having PhD degrees in Psychology and the remaining one member was M.Phil in Psychology. The treatment and assessment material was given to the committee to see its cultural appropriateness. In the adaptation process the committee discussed the content of SMILES Program and its cultural relevance. Committee reviewed the treatment and assessment material. Beside finalization of the various adaptive changes in the SMILES Program, some changes were recommended including culture and familiarity adaptation. It was resulted in replacement of some items. For example, the sound track available for activities named "Desiderata" and "Meditation" were replaced with "Muraqba" by Osho (2012). Some Urdu rhymes were used as background music instead of non-understandable English sound tracks. Style of rating scale of Knowledge Questions and Life Skills Questions were also transformed from 10 point rating scale to 5 point rating style, to make it more understandable for children.

Step III: Consultation with experts and parents. It was further decided to take feedback from practicing psychologists and parents. Four practicing psychologists from Islamabad and Rawalpindi (Pakistan) were contacted, who had knowledge and understanding of child psychopathology. These psychologists were asked to assess the original material and translated material of SMILES Program to recognize the unsuitable or inappropriate points and to suggest alternative options wherever possible. They appreciated the aims and objectives of this research. They also encouraged to move ahead from simple correlational and diagnostic researches in clinical settings to do some experimental nature of studies.

Comments and opinions from parents were also taken belonging to 5 families. Among them, three families had depressive mothers so their husbands were considered for getting information, and two families had depressive fathers, so their wives were considered for getting information. SMILES Program was briefly introduced to motivate the parents. Parents were very happy to see an intervention plan like SMILES Program to and anticipated that it would help their children.

Step IV: Committee Approach. The Urdu translations accomplished by bilingual experts were assessed by a committee of four psychologists including researcher herself. Each activity and questionnaire was discussed vigorously. Some of the statements were rephrased and modified slightly to make them more understandable. The emphasis of committee members was on conceptual equivalence. The translation and adaptation process was finalized in ten committee meetings.

Step V: Back translation of SMILES Program. Cross cultural researchers recommend back translation method for valid translation and adaptation. In back translation, main language is translated into a desired language and then back translated into the source language by translators. Berkanovic (as cited in Chishti, 2002) has shown that measurement tools that are translated through double process show higher stability and validity than those that are translated from main to desired language only. The Urdu translated SMILES Program was back translated into English as verification of initial translation and to identify points of uniformity or difference between the two versions. Back translation was carried out by two bilingual Psychologists, three faculty members of department of Psychology and four doctoral students of Psychology, who were not exposed to the SMILES Program (both assessment and treatment material), were provided with Urdu translation of SMILES Program to back translate the items of assessment material and treatment material into English. Each translator translated the Urdu content.

Step VI: Committee Approach. After receiving the back translations, the theoretical and linguistic equivalence between the back translated and the original SMILES Program were thoroughly checked by the same committee. They had found the match between back translated and the original content. However, in the process of translation; only those words were selected that were commonly used by Pakistani population. Finally, the Urdu translated content was arranged in the same order as given in the original program. The same sequence of committee approaches were followed as mentioned in step-IV.

Phase II: Pilot study. After adaptation of the entire package (assessment material and treatment material), the program was finalized for the pilot study. The aim of this phase was to check whether it was conveying the best meaning and understandable for the target sample.

Procedure. After getting permission from the Psychiatry departments of the hospitals, patients (parents) were contacted. Head of department assigned a medical officer to approach the patients in Outdoor Patient Department and Indoor Patient Department. As a first step Siddiqui Shah Depression Scale

(Siddiqui & Shah, 1997) along with the Informed Consent Form was administered on them to reconfirm their diagnosis. Parents were requested to bring their children and adolescents with them to the hospital on the next visit. One child or adolescent, who was reported by parents to exhibit more behavioral problems, was taken from each family. As the Parents, who were mentally ill, they were not expected to rate their children on Child Problem Checklist (CPCL) (Tariq & Hanif, 2007), therefore, parent who was mentally healthy/non-depressed were asked to respond on the Child Problem Checklist (CPCL). A room was allotted by the hospital management to the researcher for the administration of translated and adapted SMILES Program on the children of depressed parents. Ten children and adolescents of ten parents were collected in a room at Benazir Bhutto Shahid Hospital, as consent of parents was already taken to bring their children to this venue. They all were briefed about the treatment plan with assessment tools. On the first day translated Life Skill Question, translated Knowledge Question and Child Problem Checklist (CPCL) were administered on children and adolescents to check the comprehensibility and understandability of the translations. Treatment material of SMILES Program was administered on the next day. Implementation of different activities of SMILES Program was distributed in following nine sessions.

Week 1: SMILES Session I with children and adolescents
Mental illness education, Create a Card
SMILES Session II with children and adolescents
Children on a tree, Compliments,
Week 2: SMILES Session III with children and adolescents
Desiderata, Family drawing
SMILES Session IV with children and adolescents
Favorite pet/object/person, Feelings story
Week 3: SMILES Session V with children and adolescents
Friends drawing, 'It's good to be me' game,
SMILES Session VI with children and adolescents
Ice-breaker- an introduction, Inner-view
Week 4: SMILES Session VII with children and adolescents
Ideal family meditation, Meditation
SMILES Session VIII with children and adolescents
Outdoors, Photograph
Week 5: SMILES Session IX with children and adolescents
Pie chart, Problem solving

Each session was of three to four hours duration. The first author conducted all sessions, however staff of hospitals assisted for conducting group sessions and keeping record of sessions. Refreshments were also provided by the end of each day and session to children.

Further amendments in the program were brought keeping in view the challenges encountered during implementation phase (e.g., reformulation of feeling story). The program was modified by the difficulties that were observed during this tryout phase. Since the concept of child training is entirely new for mental health practitioners and parents in Pakistan, so implementation phase provided information regarding how the program could be made more applicable for Pakistani families. For example, children were unable to understand an activity named "Feeling Story", so equivalence was generated and finalized after committee approach by considering judgmental validity. A committee of two professors of Urdu and the first author was formulated to generate the equivalence of "Feeling story" in Urdu. They wrote a story by keeping in mind the original content, plot and moral of the story. The same sample of parents was requested to spare their children for one hour in order to see the comprehensibility of this story. During administration it was found out that the children and adolescents easily understood and labelled the emotions in the story.

Results

Table 1
Cronbach's alpha reliability coefficient of Research Instruments (n=10)

Scales	No. of Items	Alpha Coefficient (α)
Siddiqui Shah Depression Scale	36	.62
Child Problem Checklist	80	.88
Knowledge Questionnaire	10	.75
Life Skill Questionnaire	10	.53

Cronbach's alpha reliability coefficients suggest that all the research instruments are reliable, ranging from .53 to .88.

Table 2
Inter-scale correlations (n=10)

		1	2	3
1	CPCL	---	-.73*	-.89**
2	KQ	---	---	.65*
3	LSQ	---	---	---

Note. $^{**}p<.01$, $^{*}p<.05$, CPCL=Child Problem Checklist, KQ=Knowledge Questions, LSQ=Life Skill Questions

Table 2 shows correlation between children behavioral problems, knowledge and life skills. It indicates that decreased knowledge and life skill leads to increased behavioral problems in children.

Table 3
Pearson Product Moment Correlation between original, forward translated and backward translated version of Knowledge Questionnaire (KQ) and Life Skill Questionnaire (LSQ) (n=10)

		1	2	3
1.	Original	-	.74**	.82**
2.	Forward translated (Urdu)	-	-	.87**
3.	Backward translated (English)	-	-	-

Note. $^{**}p<.01$

Table 3 shows significant positive correlations between original, forward translated (Urdu) and backward translated (English) version of Knowledge Questionnaire (KQ) and Life Skill Questionnaire (LSQ).

Table 4 indicates the positive correlation between parental depression and children behavioral problems. As the parental depression increases, behavioral problems among children also increase significantly.

Table 4
Pearson Product Moment Correlation between parental depression and children behavioral problems (n=10)

	Children behavioral problems
Parental depression	.65**

Note. **p<.01

Discussion

Since the indigenization of the contents of psychological tests or therapeutic plans for any culture involves both adaptation and translation, the main objective of our study was the translation and adaptation of SMILES Program in Pakistani context and to establish its psychometric properties. This process involved cycles of translations, adaptations, field testing, and modifications in adaptation. A rigorous psychometric evaluation of all assessment material was carried out. Psychometric evidence was supported by reliability, validity and item-total correlation. Alpha Reliability Coefficients of Child Problem Checklist, Life Skills Questions and Knowledge Questions were satisfactory. Item-total Correlation of all the scales was significant. Validity evidence showed high divergent validity by indicating the significant negative correlation between children behavioral problems, knowledge and life skills. It was also supported by correlations of the original assessment tools of SMILES program with forward translated and backward translated version.

Pilot study was conducted to see the phenomenon of correlation between children behavioral problems and parental depression; and test the comprehensibility and feasibility of the translated and adapted version of SMILES program. Significant positive correlation between parental depression and children's behavioral problems in the present study coincides with the existing literature in the West (Wulczyn, 2005; Steinberg & Morris, 2001). As with many ongoing stressors individuals are reluctant to disclose their family situation to others for fear of the attached stigma. This result in a sense of isolation for the child, and the burden of responsibility for dealing with the day-to-day difficulties of having a mentally ill parent can often rest solely with the child or his or her siblings. Supportive and therapeutic services for these children are of paramount importance. Byrne et al., (2001) also recommended the involvement of other family members in therapeutic setting along with identified depressed parents.

Pilot testing resulted in some changes or modifications in SMILES Program including alternate "feeling story", because children pointed out that it was not clear to understand the translated "feeling story". So equivalence was developed with the help of experts.

Similar experimental work was carried out by Luntz (1995); Hinden, Biebel, Nicholson, Henry, & Stier (2002); and the British Columbia Schizophrenia Society (BCSS; 2003). They reviewed different programs that were designed for children of mentally ill parents. These programs intended to give support to the child, act as his or her helper, aware the child more about their parent's mental state, and improve the quality of relationship between parent and child. Some programs have precise elements for other family members, whereas others are specifically for the children. Hinden, Biebel, Nicholson, Henry, and Stier (2002) illustrated five programs in the United States, such as the Invisible Children's Program in Orange County, New York; whereas Cowling (1999) explained several Australian programs, such as the children and mentally ill parents project (Cuff & Pietsch, 1997). BCSS (2003) briefly described over 20 programs in Canada, the United States, and Australia. Some positive outcomes have been reported as the parents have reduced rate of getting hospitalized, children feel free to discuss their family problems, children have increased ability to share their own issues and improved social skills, and they also have more knowledge about parental illness. The outcome details of most programs, are only reported in in-house documents rather than in peer-reviewed journals, therefore it is difficult for researchers and clinicians to access the information. Hinden et al. (2002) also discussed the deficiency of an empirically supported evidence base plans. Although most available programs may report valuable outcomes, few have empirical evidence to support their claims.

Adaptation of SMILES program has many advantages over construction, as it limits duplication of efforts, saves developmental cost and helps in achieving fairness in assessment process. Subsequent studies to implement the SMILES program on children and adolescents separately will be a step forward toward the validation of this plan throughout the country. This study is a poineering work in the field of therapeutic interventions for children of parents with psychiatric problems. In future to see the effectiveness of this program, it is recommended to implement and test it on the children of parents with diverse psychiatric problems and to see its relative effectiveness on them. The study provides guidline to future researchers who are interested in the adaptation of therapeutic and skill enhancing programs in different cultural context.

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