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Translation and Cultural Adaptation of the Hopkins Symptom Checklist-25 (HSCL-25) Into Nepalese for Use with Bhutanese Refugees

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Abstract

This article presents a translated and culturally adapted version of the Hopkins Symptom Checklist-25 (HSCL-25), a measure of anxiety and depression, into Nepalese, the language of the Bhutanese refugee population. In this study, focus groups with three Bhutanese refugee men, and two women, living in the United States, proved invaluable to enhance linguistic accuracy and semantic equivalence. Several items on the HSCL-25 were found to be colloquialisms specific to the English language and others were deemed culturally inappropriate. It may be necessary to conduct separate focus groups interviews with men and women in some cultural groups to achieve authentic and valid responses.

Keywords

Bhutanese, refugees, Nepalese, Hopkins Symptom Checklist-25 (HSCL-25), instrument translation

As the influx of displaced and refugee populations continues to increase in the United States (US) and Europe, so too does the complexity and challenge of delivering culturally and linguistically appropriate healthcare services. Refugees cross international borders and flee their homelands due to persecution because of race, religion, nationality, or membership in a particular social or political group (United Nations High Commissioner for Refugees [UNHCR], 1992). Bhutanese refugees began arriving to the US from camps in Nepal in 2007. Since then, 88,770 Bhutanese refugees have been granted asylum in the US, and the numbers are expected to rise (International Organization for Migration (IOM), 2014). Many of these resettled Bhutanese refugees have experienced violence, torture, and profound loss, which place them at risk of mental health problems.

Refugees are at risk of psychological disorders due to both past experiences of trauma and to the overwhelming stress of resettlement. The World Health Organization reports that more than 50% of refugees present with mental health

problems ranging from chronic mental disorders to trauma and distress (World Health Organization (WHO), 2012). Depressive disorders among refugees range from 42% to 89%, and rates of post-traumatic stress disorder (PTSD) are estimated to be 50% or higher (Jaranson et al., 2004; Silove, Sinnerbrink, Field, Manicavasager, & Steel, 1997).

It is essential that screening tools be translated and culturally adapted in order to reliably assess the mental health needs of refugees coming from different countries. This study was part of a larger study to translate and culturally adapt two mental health screening instruments, the Hopkins Symptom Checklist-25 (HSCL-25) and the Harvard Trauma Questionnaire (HTQ), into Nepalese for use with Nepali speaking Bhutanese refugees. In this paper we present the findings from the HSCL-25 translation only; the results of the HTQ will be presented elsewhere.

Background of Bhutanese Refugees

Toward the end of the 19th century, families from Nepal began migrating to the southern areas of Bhutan where they continued to maintain their traditional rites, language, and customs (Schinina, Sharma, Gorbacheva, & Mishra, 2010). These Nepalese-speaking people were referred to as "Lhotshampas," meaning "People from the south" by the native people of Bhutan, a moniker that continued to the current era (International Organization for Migration (IOM), 2008).

The majority of the Lhotshampa people are Hindu, in contrast to the northern Bhutanese, who are primarily Buddhist. In spite of their highly distinctive Nepalese language, culture, and religion, Lhotshampa were still able to participate in public life and coexist peacefully with other ethnic groups in Bhutan. However, in the mid-1980s, Bhutan's king and the ruling Druk majority became worried that the growing Lhotshampa population would threaten the traditional Buddhist culture of the Druk Bhutanese (Maxym, 2010; Shrestha et al., 1998). Laws were then passed in Bhutan that created second-class citizenship for the Lhotshampas (Schinina et al., 2010). The government initiated a campaign known as "One country, one people" with new policies that imposed the Druk dress code, religious practices, and language on all of the people living in Bhutan. These new policies were clearly directed at the Lhotshampa people since they did not wear the same traditional dress, practice the same religion, or speak the same language as the northern Bhutanese (Maxym, 2010). When the Lhotshampas grew frustrated and began to protest against the new policies, the government of Bhutan violently stifled their protests, and more than 100,000 fled from Bhutan to refugee camps in southeast Nepal from 1990 to 1994 (Schinina et al., 2010). Unfortunately, prior to their arrival in the US these Bhutanese refugees had suffered in Nepal's refugee camps for almost 20 years, and many became victims of ongoing violence, including torture and rape.

It should be noted that some Bhutanese refugees might consider *Lhotshampa* a derogatory term imposed on them from the ruling class in Bhutan. The authors present this term only because of its use in the literature to distinguish between those Bhutanese who were persecuted and forced from Bhutan from those who were not.

Bhutanese Refugee Mental Health

In 2010, the disproportionately high number of attempted and successful suicides among the resettled Bhutanese refugees in the US came to the attention of humanitarian and governmental agencies (Schinina et al., 2010). Schinina et al. (2010) reported that the suicide rate among Bhutanese refugees was over three times that of average US residents and other refugee groups. The reasons cited for suicide in the Bhutanese refugee community were mainly shame (particularly that connected to gender-based violence), overwhelming burden of responsibility, feeling unsupported, alcohol abuse, or a combination

of these factors (Schinina et al., 2010). Refugees who had been thrust into non-traditional roles as family providers or separated from their traditional family support networks were particularly at increased risk of suicide during resettlement (Schinina et al., 2010).

The stress of resettlement combined with losses place Bhutanese refugees at risk of anxiety and depression in their new countries. Murray, Davidson, and Schweitzer (2010) identified several challenges to the cultural appropriateness of psychological assessment techniques that may impede access, utilization, and effectiveness of services: cultural competence of personnel who conduct assessments, linguistic demands, and cultural barriers. Due to this unique set of challenges, there is an ongoing need for information on culturally validated and translated mental health assessment tools for refugee clients.

Instruments utilized in a cross-cultural setting cannot be simply translated into another language, rather they must be culturally adapted using a consistent and reliable process to ensure linguistic equivalency and instrument validity (Mollica, McDonald, Massagli, & Silove, 2004). In this study we attempted to reach this standard by translating and culturally adapting the HSCL-25 for use with Bhutanese refugees who were resettled to the US.

Hopkins Symptom Checklist-25 (HSCL-25)

The HSCL-25 is a measure of symptoms of anxiety and depression and was initially developed to assist clinicians in assessing the mental health of English-speaking patients in primary care settings (Hesbacher, Rickels, Morris, Newman, & Rosenfeld, 1980). This instrument has been used extensively to assess refugee populations for depression and anxiety as well as to measure outcomes of interventions (Mollica et al., 2004). The HSCL-25 instrument consists of two parts: Part I has 10 items for anxiety symptoms; Part II has 15 items for depression symptoms. The scale for each question includes four response categories ("Not at all," "A little," "Quite a bit," and "Extremely," rated 1 to 4, respectively). The scale has consistently shown, in diverse populations, that the total score for Parts I and II is highly correlated with severe emotional distress of unspecified diagnosis, and the depression score (Part II) is correlated with major depression as defined by the Diagnostic and Statistical Manual of the American Psychiatric Association (2000). The HSCL-25 is sensitive to symptom change over time, providing quantitative estimates of improvement with intervention (Mollica et al., 2004, p. 7). The instrument has been translated into over 30 languages (Lavelle, 2011) and found to be reliable and valid in a variety of cultural groups and languages (Kleijn, Hovens, & Rodenburg, 2001). Prior to this study, the HSCL-25 has not yet been translated into Nepalese and culturally adapted for use with Bhutanese refugees living in the US.

Methods

The design of this study was a cross-cultural translation (English to Nepalese), blind back-translation (Nepalese to English), and validation of the HSCL-25 with a focus group of five Bhutanese refugees. This design was used to determine if the translated Nepalese HSCL-25 was equivalent in meaning to the words and concepts in the original English version and culturally relevant and acceptable for use with Bhutanese refugees.

The Harvard Program for Refugee Trauma Guidebook and Manual (Mollica et al., 2004) was used as a reference in the translation and adaptation of the HSCL-25 into Nepalese. In this Manual the three steps used to translate and culturally adapt mental health instruments are: (1) translation from English into the local language; (2) blind back-translation to the original English; and (3) comparison and consensus of the translation and back-translation by an expert group. It is recommended that the experts selected for this process be well informed of the

idioms for emotional suffering in the local community as well as Western mental health concepts (Mollica et al., 2004, p. 9).

Two bilingual men translated the English version of the HSCL-25 into Nepalese; one was a Bhutanese refugee and the other a first generation Nepalese immigrant who was raised in the US. The resultant document was then blindly back translated by a third bi-lingual Bhutanese refugee and checked by the second author (JL) who is also bi-lingual in Nepalese. Once the agreed upon version of the HSCL-25 was finalized, the study was approved by the University Institutional Review Board (IRB), and focus group participants were recruited. The second author identified participants through the local Bhutanese refugee community center and a local English-as-Second-Language class attended by the refugees.

Five adult Bhutanese refugees (three women and two men) participated in the focus groups to discuss the instrument. We intentionally recruited a majority of women to balance the social dominance of men in a culture in which women are often less educated and less outspoken than men (Center for Disease Control (CDC), 2014). Since the focus group participants were considered a very vulnerable population, every effort was made to protect their rights and anonymity in this study. While this study posed minimal risks to the participants, there was a risk that personal information shared within the group could be shared among the community. We were also sensitive to the fact that some of the topics discussed within the group might cause mental distress. Therefore, a statement of confidentiality and informed consent was translated into Nepali and read by the interpreter prior to the start of each focus group to advise the participants of these potential risks. In addition, information about support and referral for mental health treatment was provided for any participant if needed

A non-Nepali woman from the United Kingdom who was bi-lingual and literate in the Nepalese language, and lived and worked in Nepal over 25 years prior to this study, interpreted each focus group. At the beginning of each focus group, participants were informed that the purpose of the study was to create a culturally and linguistically appropriate version of the HSCL-25 in the Nepalese language. They were asked to focus their discussion on the accuracy of the translation and reminded to not provide personal information in response to each of the survey items. They were also reminded that these focus groups were not intended to screen each of them individually for symptoms of depression or anxiety.

Verbal consent in the participants' native language was obtained at the beginning of each focus group because most of the Bhutanese refugees are non-literate. However, a copy of the English version of the informed consent was also provided to each participant in case they wanted to review it later with a bilingual family or community member who could read English. The statement of consent explained the purpose of the study, the participant's role in the focus group, the ability of each participant to withdraw from the study at any time, and the importance of maintaining confidentiality of the information shared within the focus group.

Two 90-minute audio-recorder focus groups were conducted at a local community center that was well known to the Bhutanese refugees. During the focus groups, one of the male participants read each of the translated Nepalese items in the HSCL-25 aloud, and the participants discussed each item. These discussions were interpreted into English and captured on the record. After the group discussion of each item was exhausted, the original English was read aloud. The interpreter and bi-lingual participants concurred on equivalence to the original English version. At the conclusion of each focus group, participants received a $25 gift card.

The researchers and the interpreter reviewed the audio-recordings so that corrections and

adjustments could be made to the instrument. After further changes were made, a final meeting was held with the researchers and one of the translators to clarify and finalize the HSCL-25 translation based on the focus group feedback.

Findings

The data for this study were collected through audio-recordings of the focus groups and observation notes taken during several meetings with the translators and the two focus group sessions. This information was used to complete the final Nepalese version of the HSCL-25. These discussion notes are presented in Table 1.

The focus group participants were two middle-aged men and three middle-aged women. Both men spoke English that was readily understood by the investigator, and the women spoke only one or two English words. It was necessary for the researcher to redirect the men on occasion to allow the women to give their opinions. At one point, when the researcher asked the women for their feedback, one of the men responded, "they understand it." It was necessary for the researcher to remind the group that it was important for the women to speak in the group even if they did understand.

The participants had to be reminded on several occasions that the study purpose was to evaluate the translation and not necessarily to answer each item with personal responses. For example, when discussing depression symptoms, one of the women responded, "No, I am not depressed or suicidal." Another woman responded that she was "afraid to die." When discussing item 12, "Blaming yourself for things," one woman said this is like "when you are doing something and don't have the wisdom to know it is not your fault." Another woman used a personal example of blaming herself for not attending English classes that were offered in the refugee camps even though she was consumed with financial and personal responsibilities at the time.

Throughout both of the focus groups, there was consensus between the interpreter and the participants that the initial translations of the HSCL-25 used advanced terminology, or "big words" as one of the men stated, indicating that the translation would not be understood by the average Bhutanese refugee. For example, the original Nepalese translation for item 24 in the depression subscale, "Feeling everything is an effort," was not easily understood by any of the participants. The Nepalese word used, *priapu,* was not a common word in spoken Nepalese and the men stated that this word was used only by academics. One of the female participants had never heard this word.

Prior to each focus group discussion, the researchers explained what the words depression and anxiety meant in the English language to allow the participants to fully understand the purpose of the instrument and the concepts so they could help us establish equivalent words and/or phrases in Nepalese to convey their meaning. The word for depression, *udashinata,* was easily translated into Nepalese, but the English word for anxiety was not.

Metaphors and colloquialisms used in the English language version of the HSCL-25 were also not easily translated or understood. For example, item 18 in the depression subscale, "Feeling blue," has a particular meaning in the English language. However, once it was explained that the term was symbolic and not intended to be literal the focus group came up with the Nepalese translation that meant "a feeling of overcast or darkness," which captured the semantic meaning.

Item 14, "Loss of sexual interest or pleasure," was difficult for the female participants to discuss in the presence of men, especially those members of their community. While the men easily understood the phrase, the women expressed discomfort in discussing this item. The women stated that they would only describe this as meaning "a person does not want to marry someone else." They explained that

they understood the statement but would never use the word for "sex" with men present. However, they did say they would be able to speak about this topic easily with another woman or female practitioner. In addition, both the men and the women in the focus group thought this item might only be appropriate to use for Bhutanese who were married since premarital sex is not acceptable and very rare.

Some of the phrases and terminology used by the Bhutanese participants were also specific to gender. For example, item 24 in the depression subscale, "Feeling everything is an effort," was difficult to translate into a phrase that was acceptable for both the men and women in the group. Initially, the men did not understand the word phrasing at all, and there was a discussion between the men and the interpreter about the terminology that lasted almost 20 minutes. The women understood this phrase to mean, "feeling lazy," However; the men disagreed stating that the term for "laziness" in Nepalese is almost exclusively used by women concerning household chores. The focus group found it difficult to find a statement in their language that separated the idea of being physically unable to complete activities of daily living versus being mentally unable to complete them. The new translation that was agreed upon by the focus group was "not having the mind or will to do things."

After the feedback from the focus group was analyzed, changes were made to the translated version of the HSCL-25, and the final version was sent to a third translator for clarification of spelling and meaning, and typing in Nepalese script. This final translated Nepalese version is presented in Table 2.

Discussion

The focus group participants were an essential part of the translation process. They gave insight into why certain items were difficult to translate and feedback about those that were offensive or culturally inappropriate. Several of the items on the HSCL-25 survey were gender sensitive. In particular item 14 on the depression subscale, "Loss of sexual interest or pleasure," was acceptable by the men in the focus group, but not the women. Other studies that have translated the HSCL-25 for use with other non-English linguistic and cultural groups also found this item to be culturally inappropriate. For instance, in a study of Congolese adolescents (Mels, Derluyn, Broekaert, & Rosseel, 2009), the authors recommended removing this item. In another translation study of the HSCL-25 into the Dinka language for use with South Sudanese refugees, the authors found item 14 to be offensive to both men and women and recommended removal in order to be culturally sensitive to this population (Baird & Skariah, 2015). In a translation of the HSCL-25 into Tibetan, the authors discovered that sexual matters are not typically discussed in this culture; even when item 14 was removed, the depression subscale maintained consistency (Lhewa, Banu, Rosenfeld, & Keller, 2007).

Several of the Nepalese words used in the original translation and back-translation were not understood by the focus group participants. This is understandable since translators who are hired to work in research studies are often more educated and have more advanced language skills than members of the target population. This reinforces the importance of using a focus group of native speakers to review and evaluate translated instruments before use in clinical situations or research studies.

Several items on the HSCL-25 were difficult to translate and should be carefully explained or changed for use with diverse cultural groups. Colloquialisms specific to a language or cultural group, such as "feeling keyed up" or "feeling blue," should be carefully evaluated in the target language to be certain that these phrases capture not only the linguistic but semantic equivalence.

We had difficulty translating some of the mental health constructs such as "Everything is

an effort" from English into Nepalese. The direct translation was a "lack of physical strength to do things" and this may have been understood as a physical illness rather than a mental condition. One possible explanation for this may be a lack of distinction in Asian cultures between the mind and body (Helman, 2007). Asian refugees tend to view some psychological constructs in more somatic terms rather than emotional terms (Mollica et al., 2004; Thakker & Ward, 1998), which may explain why we had so much discussion about the distinction of the difference between an emotion and a physical sensation.

There is no comparable word in Nepalese for anxiety. It has been suggested that anxiety may be a Western construct (Kleinman, Eisenberg, & Good, 1978) that cannot be applied to Asian refugees. Mollica et al. have suggested that Asian refugees experiencing mental health problems are unlikely to disclose their emotional concerns to family and healthcare providers because they tend to see mental affliction as a source of humiliation and weakness (Mollica et al., 2004). However, when we asked the focus group participants if there was a negative stigma or shame associated with having a mental problem, one of the men denied this, but one of the women stated she would not want others to know.

Implications for Future Research

This study paves the way for future research and psychiatric interventions within the Bhutanese refugee population. To our knowledge, this study is the first translation and cultural adaptation of the HSCL-25 into Nepalese. The Nepalese version can now be field tested with a larger Bhutanese refugee group in a clinical setting to evaluate reliability and validity. Since this study did not discuss the HSCL-25 instructions and responses in the focus groups, future studies should include revisions and adjustments to these elements as well. Furthermore, the framework and design of this study can be applied to future cross-cultural studies and translations of psychiatric scales in other populations. Using a mixed-gender focus group to culturally validate health questionnaires should be reconsidered in some cultural groups. In this study, the women were hesitant to voice their opinions in a setting in the presence of men with higher educational and social status. Certain items on the HSCL-25 were also found to be gender sensitive.

Conclusion

The lack of culturally and linguistically appropriate mental health screening instruments for different ethnicities and language groups makes it challenging for healthcare providers to facilitate and nurture positive health outcomes in immigrant and refugee populations. The adaptation and evaluation of the HSCL-25 in this study incorporates an understanding of patients' cultural and linguistic perspectives in order to reduce cultural distortion and render the translations meaningful and the instrument useful (Mollica et al., 2004).

For this study, the HSCL-25 was translated from English into Nepalese. Overall, it was difficult to convey the meaning of complex constructs through simple language that was easily understood by the native refugee population. The findings from the focus groups revealed to us how essential it is to use native speakers to help translate and linguistically and culturally adapt versions of mental health instruments.

Table 1. Translation and Focus Group Discussion of the HSCL-25 (n=5)

HSCL-25 (Original English)	Focus Group Discussion
Part 1. Anxiety Symptoms	Difficult to translate anxiety into Nepalese. There are different words that could be used in place of anxiety; however, they do not necessarily accurately convey the correct meaning.
1. Suddenly scared for no reason.	Well understood and consensus reached quickly. Focus group described the example of being scared as if "police are chasing a person, but no police are present."
2. Feeling fearful.	The focus group came to the consensus that the best way to describe this symptom in Nepalese means, "feeling a big fear." Agreement reached that this was translated correctly.
3. Faintness, dizziness, or weakness.	The interpreter thought the way the Nepalese translation was worded was "a funny thing to say." The words for faintness, dizziness, and weakness are similar in the Nepalese language. And these words mean, "feeling sleepy", or "unconscious" which could be confusing.
4. Nervousness or shakiness inside.	"Nervousness" is difficult to translate into Nepalese. Translator and participants agreed that this word was an English term exclusively. "Shaking" is understood and the focus group related this feeling to having "low blood sugar." One woman used the example that she "feels a little shaky inside in morning before she's eaten."
5. Heart pounding or racing.	Translation congruent and consensus reached quickly. Translation literally means, "heart palpitations or increased heart rate."
6. Trembling.	There was little discussion about this symptom. The focus group understood this translation to mean "a little bit of shaking."
7. Feeling tense or keyed up.	"Feeling tense" was understood as "tension" and being "very worried." However, "tension" was noted by the men in the focus group to be an upper level Nepalese word that was used in literature only. "Keyed up" could not be translated or understood, as it is an English language colloquialism. The final Nepalese version was, "Very, very worried. Tension."
8. Headaches.	Translation completely understood and consensus reached quickly as "head aches or head hurts."
9. Spell of terror or panic.	Focus group understood the translation to mean, "having a lot of anxiety, fearful, or terrorist actions." The Nepalese word for terror has two meanings: (1) fearful or (2) terrorist. We had to distinguish between "an external terrorist" and a "feeling of terror inside." The interpreter asked the group, "if you met a tiger in a forest, how would you feel?" The group also described the symptom as "feeling a lot of anxiety" or "feeling very afraid that you would start mumbling or muttering to yourself."
10. Feeling restless or can't sit still.	This was difficult to translate for the interpreter, and the participants agreed that the translation did not accurately convey what the English intended. Consensus was reached that the Nepalese words to be used for these symptoms would mean, "feeling impatient, unstable, and unable to sit still." However, the word for "unstable" was not necessary. It was decided that a correct interpretation was "feeling impatient and unable to sit still."

Part 2. Depression Symptoms	The subheading of Part 2 was easily translated and the focus group agreed that "depression" was easily understood and was equal to the English meaning. The participants denied any negative stigma associated with depression. However, on a personal level they explained that they would not want to state openly to others that they were depressed.
11. Feeling low in energy, slowed down.	"Feelings of weakness and lack of strength" was the literal translation. This translation accurately conveyed the correct meaning and understanding. Modifications to this translation were not necessary.
12. Blaming yourself for things.	There was no difficulty with the translation of this symptom. The focus group agreed that it meant to "blame yourself when you don't have wisdom to know that it is not your fault," or "feeling regret."
13. Crying easily.	This symptom was a straightforward translation and understood by members of the focus group. One of the men in the group suggested that the words "crying easily" would sound more coherent if preceded by "Are you experiencing symptoms of depression, such as crying easily?" This prompted a lengthy and important discussion. There was concern that if you associated some of these symptoms with a statement about depression, some may not agree with the statement because they may deny they had depression and, therefore, any of the associated symptoms of depression. We asked the participants if there was a negative stigma associated with being depressed. The men denied any stigma, however the women admitted that they would not want to "say it openly that they were depressed." One of the men stated, "people don't know when they are depressed."
14. Loss of sexual interest or pleasure.	The interpreter was not familiar with the word for sex, *sambo*, in Nepalese. One of the women in the focus group stated that this meant, "you don't want to marry someone else." The women did not feel comfortable saying the phrase "interest in sex" out loud in the presence of a man. The women were asked if they thought it was even appropriate to have this item on the survey, and they stated they would not use the word for sex if any male was present but would feel completely comfortable discussing this with a female peer or healthcare provider. The men understood this symptom to mean "no interest for sex" and were not uncomfortable explaining what they thought it meant in the presence of women. However, they did state this question may only be appropriate for married Bhutanese because premarital sex was not allowed and they would not have experienced sexual interest. The word pleasure was difficult to translate and needed two different words depending on whether the patient was male or female. There was also a lengthy discussion of the difference between "no interest in sex or loss of interest". The distinction was important because it indicated a change of interest. However, this could not be determined in those whose interest in sex was not appropriate, such as unmarried females. This symptom was translated as "no desire or interest in sex."
15. Poor appetite.	This symptom was easily translated as having a "lack of appetite." The focus group understood this to mean, "not feeling hungry."
16. Difficulty falling asleep, staying asleep.	The focus group easily understood the translation to mean, "not being able to sleep, not feeling sleepy, and staying awake all night." However, while it was more difficult to translate and explain the meaning of "staying asleep", the focus group agreed that the translation was accurate and easily understood.
17. Feeling hopeless about the future.	The translation of this symptom was accurate. The difference between the ideas of not knowing what may happen in the future and feeling hopelessness for the future conveyed the same meaning in Nepali as it does in English.

18. Feeling blue.	This was difficult to translate accurately into Nepalese because "feeling blue" is an English colloquialism. The literal translation meant, "feeling sad or painful." *Dukkha* means pain, and *dukkhit* is from the same root, meaning everything hurting. At first, the focus group participants asked if "feeling blue" was meant to be literal. When we explained that "feeling blue" means to feel sad, one male participant easily understood and stated that the women would understand as well. The women stated they understood this symptom to mean "personal thoughts and everything hurting, feeling dizzy, and not wanting to eat, or having no strength." We discussed that this sounded like the construct of depression rather than one symptom. The group understood that this pain was in "the mind only." Their terminology for this expression was translated as "feeling pain in the mind or feeling overcast, or darkness."
19. Feeling lonely.	This symptom was easily translated and understood by all members of the focus group. The group stated this meant to feel as if one was "on their own with no one to help" and "feeling loneliness and darkness."
20. Thought of ending your life.	The literal translation of this symptom was, "having thoughts of wanting to end your life." The focus group stated this meant to feel "no purpose for living because everything is hopeless but not actually thinking about ways to die," or that a person "wants to die but is afraid to die." One of the female participants responded to the interpreter that she was afraid to die. We had a lengthy discussion that thoughts of ending one's life could mean both "just thoughts" and also an intention to end one's life. We had to add an additional statement in Nepalese that having thoughts of suicide may also convey an actual intention to end one's life. *Aatma-hatyaa*is is the Nepalese word for suicide, and we wanted to use this word in the translation to include those who had thoughts of suicide.
21. Feeling of being trapped or caught.	Translated to literally mean "feeling like you are in a prison or jail." The focus group took this statement literally and believed it to mean that one cannot get out and walk. However, after a short discussion and adaptations to the translation, the focus group understood this to mean a person is "trapped by their situation or problems" and not necessarily physically trapped.
22. Worry too much about things.	Translated as "very worried about things." The focus group easily understood the meaning of this symptom and stated it meant that a person "has a lot of worries." The women of the focus group joked that women may be the only ones to have this problem as "women have all the worries and men have none." They shared with us that it is important in their culture to not show you are worried.
23. Feeling no interest in things.	The translation was accurate and conveyed the same meaning in Nepalese as it does in English. The focus group stated this meant to have a generalized feeling of having no interest in anything or no interest in everything. *Chaso* means interest in Nepalese.
24. Feeling everything is an effort.	This symptom was difficult to translate and convey the same meaning in Nepalese as it does in English. In fact, it took a 20-minute discussion to reach agreement. The male participants had difficulty reading the translated Nepalese words, and the words were not understood at all by the participants. The Nepalese word *priapu* is not commonly used in spoken Nepalese, and one of the female participants did not know this word at all. The women in the group understood this symptom to mean "feeling lazy" or having no energy to do things. However, the male participants in the group disagreed with this interpretation and stated that the terminology for laziness was almost exclusively used by women concerning housework and cleaning. The focus group found it difficult to find a statement in Nepalese that separated the idea of being physically unable to complete activities of daily living versus being mentally unable to complete them. The group finally agreed to change the wording of the original Nepalese and the new translation that was agreed upon by the focus group was "not having the mind or will to do things" and "no strength to do ordinary things."

25. Feeling of worthlessness.	The translation was inaccurate and conveyed the wrong meaning. The focus group initially understood the original translation as, “he doesn’t like what he’s doing.” One man gave an example: “When a guest comes to his house and his wife cooks food and the guest doesn’t like it, she feels useless.” The new translation of “feeling useless and feeling worthless,” which meant the same thing, was easily understood by the focus group.

Table 2. Nepalese Version of the Hopkins Symptom Checklist-25 (HSCL-25)

हप्किन्सका लक्षण मापन सुची – २५

नेपाली अनुबाद

नाम _____ मिति_____

चिकित्सक/नर्स_____

जन्म मिति _____ लिङ्ग _____बैबाहिक दर्जा _____

प्रवेश मिति _____ मानसिक उपचार _____

तल तालिकामा मानिसहरूलाई कहिलेकाही हुने लक्षणहरू र समस्याहरू दिईएका छन। कृपया प्रत्येक बुँदाहरूलाई ध्यान दिएर पढ्नुहोस र भन्नुहोस कि तपाईंलाई ती लक्षणहरूले बितेको सातादेखि आजसम्म कतिको सताएको छ। कृपया तपाईंलाई लागु हुने कोष्ठमा चिन्ह लगाउनु होला।

संख्या	भाग १ चिन्ताका लक्षणहरू	हुँदै भएन १	थोरै भयो २	निकै भयो ३	ज्यादै भयो ४
१.	बिना कारण अचानक आतिनु				
२.	डरलाग्दो सोचाइ आउनु				
३.	मुर्छापर्नु, रिंगाटा लाग्नु, वा कम्जोरहुनु				
४.	अस्थिरपनाको अनुभब वा भित्र भित्र कम्पनहुनु				
५.	मुटुको धड्कन बढ्नु वा मुटु ज्यादा ढुकढुक गर्नु				
६.	कम्पन हुनु				
७.	तनावको सोचाइ वा दबाब हुनु				
८.	टाउको दुखिरहनु				
९.	त्रासहुनु, बर्बराउनु वा आतिनु				
१०.	धैर्य गुमाउनु, छट्पटी लाग्नु				

संख्या	भाग २ उदाशिनताका लक्षणहरू	हुँदै भएन १	थोरै भयो २	निकै भयो ३	ज्यादै भयो ४
११.	निर्बलहुनु वा कम्जोर महशुस हुनु				
१२.	कुनै पनि कुरामा आफूलाई दोषी ठान्नु				
१३.	सहजै रूनु				
१४.	यौन चाहना वा सन्तुष्टी घट्नु				
१५.	खानामा रूची घट्नु				
१६.	निद्रा नलाग्नु वा तारन्तार ब्युजिनु				
१७.	भविष्यका विषयमा त्यसै निरास हुनु				
१८.	दुखान्त सोचाइ हुनु				
१९.	एक्लोपनको सोचाइ हुनु				
२०.	जीवन खतम गरिदिने सोचाइ आउनु				
२१.	थुनामापरेको वा जालमा पारिएको सोचाइ आउनु				
२२.	कुनै विषयमा ज्यादै चिन्ता लिनु				
२३.	कुनै कुरामा रूचिनै नजानु				
२४.	जे गर्न पनि भर चाहिन्छ भन्ने सोचाइ आउनु				
२५.	महत्वहिन भएको सोचाइ आउनु				

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Instructions for the scoring were not translated into Nepalese. The responses are summed and divided by the number of answered items. There are three scores: anxiety score is derived by adding items 1 thru 10 and dividing this number by 10. The depression score is obtained by adding items 11 thru 25 and dividing by 15. The total score is obtained by adding all 25 items and dividing by 25. Individuals with scores on anxiety and/or depression and/or total > 1.75 are considered symptomatic. See Harvard Manual for Measruing Trauma and Torture for further explanation of scoring and additional information (Mollica et al., 2004).

The translated instrument has not been evaluated for accuracy with the DSM diagnosis of clinical depression in this population.

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