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ADAPTATION AND PSYCHOMETRIC VALIDATION OF THE URDU TRAUMA RECOVERY MEASURE: A STUDY OF PAKISTANI UNIVERSITY STUDENTS

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ABSTRACT

The primary aim of this study was to devise the Urdu translation of the Trauma Recovery Measure (TRM; Smith, 2022) and investigate its ability to be used with Pakistani university students. The project was carried out in two phases: first, translation of the scale by a forward-backward method, and second, measurement of the psychometric properties of the scale. The number of students who participated in this study was 400 students through convenience sampling from different universities in Pakistan. The full scale was found to be reliable (Cronbach's alpha = .721). An exploratory factor analysis confirmed the three-factor structure of the original scale, and three factors were identified: Validation, Liberation, and Positive Self. Confirmatory factor analysis showed the model fit the data extremely well (CMIN/DF = 1.056, GFI = .971, AGFI = .960, CFI = .997, IFI = .999, TLI = .996, RMSEA = .012). The scale had a significant positive correlation with the Self-Compassion Scale Short Form (r = .206, p = .040) and a significant negative correlation with the Kessler Psychological Distress Scale (r = -.060) to gain convergent and divergent validity, respectively. The findings indicate that Urdu TRM is a valid and suitable instrument for measuring trauma recovery among Pakistani students.

Keywords: *Trauma recovery measure, validation study, self-compassion, psychological distress, Pakistan.*

Introduction

There is very little that can be more troubling than a traumatic experience. Major events can, however, destabilize a person's psychological foundation in ways that persist long after the event has happened, such as auto accidents, loss of a loved one, violence, and surviving a natural disaster (American Psychiatric Association, 2013). These types of experiences can develop to post-traumatic stress disorder (PTSD) in many people. The experiences lead to Post-Traumatic Stress Disorder (PTSD) in many. Many experiences like these can develop Post-Traumatic Stress Disorder (PTSD) as a result, which involves more than simply feeling distressed. It contains flashbacks and intrusive thoughts and exceeds the norm in trying to avoid reminders of the trauma but also responds with heightened physical arousal. These symptoms combine to interfere with an individual's functioning in areas such as work and relationships (American Psychiatric Association, 2013).

Universities represent a large source of trauma to young people. Meta-analysis of the prevalence of PTSD in students from various countries around the world showed a wide range of prevalence from 2.7% to 66% (Hu et al., 2023), demonstrating the broad spectrum of student trauma-related issues. Especially in Pakistan, the situation is worrying. Among a sample of university students of Karachi, it has been revealed that 93% had experienced at least one traumatic event and more than a quarter fulfilled the probable criteria for PTSD (Ahad et al., 2015). In the subsequent study conducted in the KP area, similar results were found in that most of the trauma children had moderate to severe symptoms, and the underlying study found that the trauma children were more likely to have moderate to severe symptoms than the males (Kazmi et al., 2022). This is a reflective pattern of mental health difficulties that occur in Pakistani society due to frequent exposure to political instability, economic shortages, natural disasters, and community violence (Rathod et al., 2017).

Trauma and Recovery

Despite the high prevalence of trauma in Pakistan, psychological research and assessment instruments have focused on assessing the dysfunctionality and symptoms created by trauma. The way of being in and out of traumatic experiences has been comparatively little studied. Trauma recovery is truly a unique and complicated psychological phenomenon, and much more than a decrease in symptom scores. However, Saint Arnault and others (2022) suggested that the typical methodologies evaluating recovery have focused on the absence of symptoms as an indicator of a healed individual, thus overlooking and failing to capture the highly personal and cognitive nature of recovery. Authentic recovery is evidenced in valuable alternative ways the survivor's thoughts and relating with him/w herself after trauma and involves a process of producing a sense of self-acceptance, restoring a sense of personal agency, reestablishing hope for the future, and coping, becoming an adaptive style of responding (Smith, 2022).

Smith (2022) described trauma recovery as a "cognitive change" process in which individuals make incremental progress toward emotion and behaviour regulation, a sense of personal empowerment, and an optimistic prediction for their own future. In this conceptual understanding, recovery is more of a continuum than a finite result. Survivors slowly move out of destructive self-blame and self-condemnation, into growing abilities to engage in self-acceptance, self-compassion, and autonomous psychological functioning. This view resonates with post-traumatic growth theory, which also views the process whereby positive changes occur within the person after experiencing adverse events as the mental factors of cognitive processing and new meaning construction (Tedeschi & Calhoun, 2004).

Self-Compassion and Psychological Distress in Trauma Recovery

In the context of trauma recovery, self-compassion is related to psychological distress.

Self-compassion research and engagement with the relationship between self-compassion and Trauma recovery has risen markedly in recent decades. According to Neff (2003), self-compassion has three components: handling with kindness instead of judgment, accepting suffering and personal failure by realizing that they are universal human experiences and not one's unique failure, and staying attuned to problem emotions and thoughts from a nonjudgmental, even holding perspective. Studies have shown that greater self-compassion is related to less severe PTSD, increased resilience, and

better post-traumatic adaptation (Munroe et al., 2022). Studying responses to trauma and positive change in adulthood, a report by Valentino et al. (2025) showed that self-compassion significantly moderated the relationship between post-traumatic symptoms and post-traumatic growth; large post-traumatic symptoms were still able to lead to positive change in those scoring higher on self-compassion. These findings align with theories of recovery outlined by Smith (2022) and informed the decision to include self-compassion as a measure of convergent validity.

General psychological distress is a theoretical expectation of a decrease in the experience of anxiety and depressive symptoms as one moves through the recovery process from trauma. As a person makes strides in recovery and develops more positive thinking and patterns of relationship with what occurred, one could predict that the overall level of non-specific distress would decrease (Kessler et al., 2002; Smith, 2022). Based on this expected inverse relationship between recovery and distress, it is suitable to use distress as a criterion measure to test the divergent validity of instruments aimed at measuring the trauma recovery process.

The Trauma Recovery Measure

Smith's (2022) creation of the Trauma Recovery Measure (TRM) was in response to a significant need for strengths-based recovery-oriented psychological assessment tools. The TRM is different from traditional trauma tools, which focus on measuring symptoms, in that it attempts to measure positive aspects of the healing process. A 15-item instrument developed for adults 18 years and older who have experienced trauma exposure and is organized into three theoretically based subscales. The validation items include 1, 4, 5, 8, 10, and 13, and measure a survivor's self-worth and self-acceptance despite their traumatic experiences. Items 2, 3, and 6 reflect the individual's ability to make autonomous decisions and progress through life without being constrained by past experiences and thus fall under the Liberation subscale. The Positive Self subscale consists of items 7, 9, 11, 12, 14, and 15, which measure positive self-directed cognitions such as hope, self-compassion, and perceived personal competence. All items are rated on a 5-point Likert-type scale from 1 (Untrue of Me) to 5 (True of Me); total scores range from 15 to 75, with higher scores indicating greater recovery. The TRM scores high on internal consistency (alpha = .95), and there is evidence of adequate factor structure (CFI = .95; IFI = .95; TLI = .94) and strong convergent validity with PTSD (r = .70), psychological distress (r = .60), and post trauma cognitions (r = .77) and with self-compassion (r = .25; Smith, 2022). Before the current study, the TRM had not been translated or validated in any language other than English.

Need for Urdu Translation

Urdu is comprehensible to the nation by all fellow citizen irrespective of their regional and educational background. Notwithstanding these, there are very few Urdu language validated psychological assessment tools. Search of the literature revealed fewer than 20 questionnaires that have undergone a formal psychometric evaluation in Urdu (Ahmer et al., 2007). The use of English language instruments with Urdu speakers raises some risks that cannot be overlooked: misunderstandings, inappropriate interpretations of items in different cultures, and ultimately, results that may not accurately capture the psychological state being assessed (Bibi & Kazmi, 2021). In addition to the overall lack of Urda tools, there is no Urda trauma outcome measure that is strengths-based and recovery-oriented. Therefore, the development and validation of Urdu TRM would be a useful contribution towards research and clinical practice in Pakistan, which will help professionals to have a contextually suitable and scientifically valid framework to evaluate trauma recovery.

Aims of the Study

The purpose of the study is based on three main objectives. The major one was to make an Urdu translation of TRM, which was conducted with due care through a rigorous forward-backward translation procedure. The second was to evaluate the factor structure and internal reliability of the instrument developed in Urdu. The third was to evaluate convergent validity by using the Self-Compassion Scale Short Form (SCS-SF), and divergent validity by the Kessler Psychological Distress Scale (K10).

Method

The study consisted of two parts. Phase 1 depends on translating the TRM into Urdu, and Phase 2 focuses on the psychometric properties of the translated instrument.

Phase 1: Translation of TRM into the Urdu Language

In phase 1, TRM had to be translated into the Urdu language. Phase 1 involved the translation of TRM into the Urdu language.

Prior to any translation work being done, written authorization from the original developer of the TRM (Smith, 2022) was acquired. The forward-backward translation approach suggested by Brislin (1980) was adopted, which is the common practice in scale development studies in Pakistan (Bibi & Kazmi, 2021; Kazmi et al., 2023).

The Urdu translation of the 15 TRM items was independently produced by four bilingual translators who were fluent in both English and Urdu, and who had postgraduate qualifications in an appropriate discipline. The translators worked independently, not having access to the other translations. All the translators were oriented to the theoretical underpinnings and psychological function of the scale to maintain the same meaning of the construct as well as the linguistic meaning for each item.

Once all four forward translations were finished, the research team looked at each item in all four versions. The translations of the items that were similar were easy to complete. In instances when more than one word was used, the team discussed the option that best captured the intended psychological meaning while being natural and easy to comprehend for Pakistani university students. This process led to a single draft in Urdu.

Four additional bilingual translators who were not familiar with the original English TRM then back-translated the final Urdu draft into English, independently. The back-translations were compared item by item with the source instrument to identify any loss or distortion of meaning. If there were any differences, the Urdu equivalents were made accordingly.

After the two translation phases, a panel of experienced clinical psychologists was convened to look over the final translations. The panel members carefully considered all forward and backward translations of each item, considering the original scale, and by mutual discussion agreed on the most linguistically natural, semantically exact, and culturally fitting Urdu translation of each item. This approach is a standard method for assessing content validity and cultural equivalence in cross-cultural scale development, as it has been used in the development of scales that are reviewed by experts (Cruchinho et al., 2024; Tan et al., 2020).

A pilot sample of 30 eligible University students was administered the final Urdu TRM, where they were asked to make note of any items that were unclear or difficult to interpret. No items were identified as problematic. The Cronbach's alpha value from the pilot sample was adequate, and thus the instrument was appropriate for the main study.

Phase 2: Psychometric Properties of TRM

Sample

The total number of recruited students from the universities, and convenience sampling was made of 400 University students from all over Pakistan. Participants had to be 18 years or older and personally have experienced at least one traumatic event in their life. This criterion was confirmed by a brief screening question at the start of the questionnaire; those who did not were excluded from the study, as the TRM was created for people who have direct trauma exposure. The demographic questionnaire also included a question about the most severe trauma they had experienced from the following options: death of someone close, road traffic accident, physical injury or illness, interpersonal violence, natural disaster, academic or financial crisis, or other. Table 1 provides full demographic data, such as trauma type.

Measures

The Urdu version of the Trauma Recovery Measure (TRM-U; Smith, 2022). TRM-U is a 15-item scale that evaluates psychological revival in people who have been impacted by trauma. The items are rated on a 5-point Likert scale from 1 (Untrue of me) to 5 (True of me) for each item and summed to give an overall score (range 15–75, higher scores representing greater recovery). The scale is divided into three sub-scales: Validation (6 items), Liberation (3 items), and Positive Self (6 items). The original English version was found to be highly reliable (alpha = .95; Smith, 2022).

The SCS-SF (Raes et al., 2011) is a short form of the Self-Compassion Scale. The SCS-SF contains 12 items from the original 26-item Self-Compassion Scale (Neff, 2003) and measures six facets of self-compassion: self-kindness, common humanity, mindfulness, self-judgment, isolation and over-identification, and provides a composite self-compassion score. The problems are scored on a 5-point scale, ranging from 1 (Almost Never) to 5 (Almost Always). The SCS-SF has good internal consistency (alpha = .86 or higher) and high correlation with the full version (r = .97; Raes et al., 2011). The convergent validity measure was chosen because self-compassion is an important, theoretically central factor in Smith's (2022) model of trauma recovery.

The K10 is a widely used 10-item self-report instrument used to identify anxiety and depressive symptoms in the last 4 weeks. They are rated from 1 (None of the Time) to 5 (All of the Time), and a total score is calculated from 10 to 50, with higher scores reflecting higher levels of distress. The scale has shown excellent reliability and validity in different population groups (Andrews & Slade, 2001; Kessler et al., 2002), and an Urdu version of the scale has been validated for use in the Pakistani context (Ghafoor et al., 2010). Theoretically, psychological distress and trauma recovery should be negatively correlated (Smith, 2022), and therefore, the K10 was well-suited to testing divergent validity.

Procedure

Ethical clearance was obtained from each participating University's administration before data collection. The participants were approached individually on campus and responded was fully informed about the purpose and the confidentiality of the study, as well as the voluntary participation. Written permission was obtained from all those who decided to take part. Those who were eligible then answered the entire questionnaire battery in Urdu, which included the demographic information form, the trauma history screening question, the TRM-U, the SCS-SF, and the K10, and was completed in the same order for everyone.

Data Analysis

All statistical analyses were performed with the IBM SPSS (Version 25) and AMOS (Version 22) software. Cronbach's alpha was computed for the TRM-U total scale and sub-scales to assess the internal consistency of the TRM-U. To explore the underlying factor structure of the scale, exploratory factor analysis (EFA) was conducted with Principal Component Analysis (PCA) with Varimax rotation. The 3-factor model was then evaluated for fit in AMOS. Fit of the models was evaluated by chi-square to Degrees of Freedom (CMIN/DF), Goodness of Fit Index (GFI), Adjusted Goodness of Fit Index (AGFI), Comparative Fit Index (CFI), Incremental Fit Index (IFI), Tucker-Lewis Index (TLI), and Root Mean Square Error of Approximation (RMSEA). The values of .90 and above for GFI, AGFI, CFI, IFI, and TLI were determined to be acceptable (Hair et al., 2006; Hu & Bentler, 1999); and the values of RMSEA<.08 and<.05 were acceptable and good, respectively (Hair et al., 2006; Hu & Bentler, 1999). Convergent and divergent validity were assessed through Pearson correlations between TRM-U total scores and scores from the SCS-SF and K10 scores.

Results

Internal consistency analysis was conducted on the complete sample of N = 400 participants. The Cronbach's alpha for the 15-item TRM-U was .721, with no cases excluded, which indicates an acceptable level of reliability

Validation of TRM-U

Figure 1 depicts the three-factor structural model of the TRM-U. Exploratory factor analysis using Principal Component Analysis with Varimax rotation was applied to all 15 items. The Kaiser-Meyer-Olkin measure of sampling adequacy was .822, and Bartlett's test of sphericity was statistically significant (p<.001), jointly confirming that the data were suitable for factor analysis (Field, 2009).

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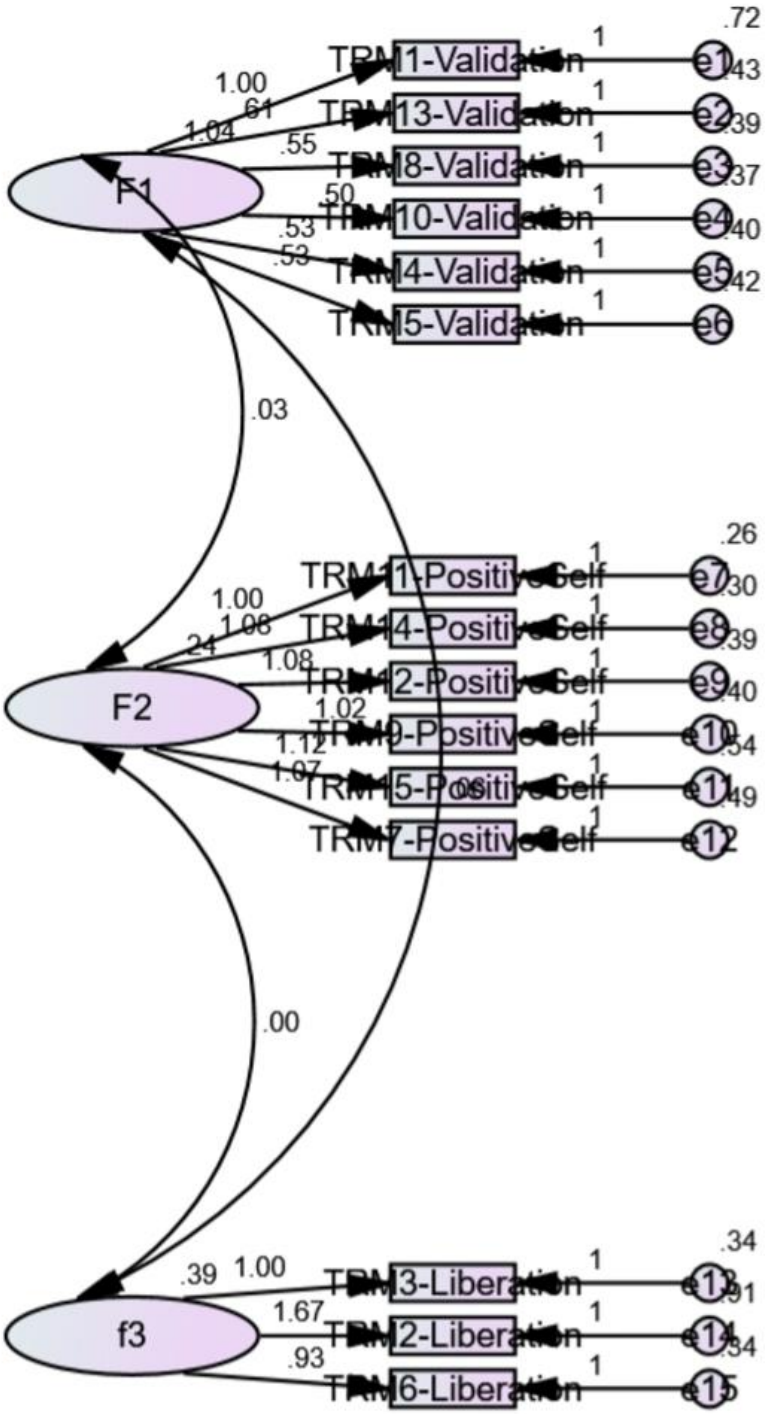

Figure 1: Illustration of Three-Dimensional Trauma Recovery Measure Urdu Version.

Table 1: *Demographic Characteristics of Sample* (N = 400)

Demographics		Frequency	Percentage %
Age	20-25	305	76.3
	25+	95	23.8

Gender	Male	171	42.8
	Female	229	57.3
Family Type	Joint	188	47.0
	Nuclear	211	52.8
Nature of Trauma	Death of a Loved One	112	28.0
	Road Accident	74	18.5
	Physical Injury or Illness	68	17.0
	Interpersonal Violence	56	14.0
	Natural Disaster	48	12.0
	Academic or Financial Crisis	26	6.5
	Other	16	4.0

Note. TRM-U = Trauma Recovery Measure Urdu Version.

Table 1 shows the demographic characteristics of the sample, including age, gender, family type, and the nature of the reported traumatic experience.

Table 2: ***Communalities Values of Extraction Method by Using Principal Component Analysis of TRM-U*** **(N = 400)**

Item No.	Value
1	0.644
2	0.686
3	0.688
4	0.527
5	0.505
6	0.674
7	0.469
8	0.549
9	0.492
10	0.522
11	0.559
12	0.510
13	0.558
14	0.555
15	0.472

Note. Extraction Method: Principal Component Analysis.

Table 2 presents the communality values for all 15 TRM-U items.

Table 3: ***Factor Loading for Exploratory Factor Analysis by Using Varimax Rotation Analysis of TRM-U*** **(N = 400)**

Item No.	Factor 1	Factor 2	Factor 3
1	.800		
13	.746		
8	.739		
10	.722		
4	.715		
5	.707		
11		.747	
14		.743	
12		.714	
9		.697	
15		.685	
7		.684	
3			.829
2			.826
6			.820
% Variance	22.66	19.81	13.59
Cumulative Variance	22.66	42.47	56.06
Kaiser-Meyer-Olkin Measure	.822		
Bartlett's Test of Sphericity	p<.001		

Note. Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. Rotation converged in 4 iterations.

Table 3 reports the factor loadings for the three-factor solution obtained through the exploratory factor analysis.

Table 4: ***Model Fit Indices for TRM-U*** **(N = 400)**

Models	CMIN/DF	GFI	AGFI	CFI	IFI	TLI	RMSEA	PCLOSE
TRM-U (3 factors)	1.056	.971	.960	.997	.999	.996	.012	1.000

Note. TRM-U = Trauma Recovery Measure Urdu Version; GFI = goodness-of-fit index; AGFI = adjusted goodness-of-fit index; CFI = comparative fit index; IFI = incremental fit index; TLI = Tucker-Lewis's index; RMSEA = root mean square error of approximation; PCLOSE = p of close fit.

Table 4 presents the confirmatory factor analysis model fit indices for the TRM-U.

Table 5: ***The CFA Reliability and Validity Results for Final Model of TRM-U*** **(N = 400)**

Construct	Items	Factor Loading	Cronbach's Alpha (>.7)	CR (>0.6)	AVE (>0.5)
Factor 1 (Validation)	1	.800	.721	.878	.546
	4	.715			

	5	.707				
	8	.739				
	10	.722				
	13	.746				
Factor 2 (Positive Self)	7	.684	.75		.861	.507
	9	.697				
	11	.747				
	12	.714				
	14	.743				
	15	.685				
Factor 3 (Liberation)	2	.826	.80		.865	.680
	3	.829				
	6	.820				

Note. CFA = confirmatory factor analysis; TRM-U = Trauma Recovery Measure Urdu Version; CR = composite reliability; AVE = average variance extracted.

Table 5 summarizes the reliability and validity indicators from the confirmatory factor analysis for the final TRM-U model.

Table 6: ***Correlation Among TRM-U, SCS-SF, and K10*** **(N = 100)**

Scales	TRM-U	SCS-SF
TRM-U	-	.206*
SCS-SF	.206*	-
K10	-.060	-.584**

Note. TRM-U = Trauma Recovery Measure Urdu Version; SCS-SF = Self-Compassion Scale Short Form; K10 = Kessler Psychological Distress Scale. *p<.05. **p<.01.

Table 6 presents the correlations among TRM-U, SCS-SF, and K10. TRM-U showed a significant positive correlation with SCS-SF (r = .206, p<.05), supporting convergent validity. This means that higher trauma recovery was associated with higher self-compassion. TRM-U showed a negative correlation with K10 (r = -.060), supporting divergent validity, indicating that more advanced recovery corresponded with lower psychological distress. The SCS-SF also showed a significant negative correlation with K10 (r = -.584, p<.01), consistent with the theoretical expectation that greater self-compassion is associated with lower distress.

Table 7: ***Gender Differences on TRM-U*** **(N = 400)**

Variable	Males (n = 171)		Females (n = 229)		*t*	df	*p*	95% CI	
	M	*SD*	*M*	*SD*				LL	UL
TRM Total Score	4.06	.408	4.04	.423	.388	398	.698	-.066	.099

Note. TRM-U = Trauma Recovery Measure Urdu Version; CI = confidence interval; LL = lower limit; UL = upper limit.

Table 7 showed gender comparisons on TRM-U total scores.

Table 8: *Family Type Differences on TRM-U* (N = 400)

Variable	Joint (n = 188)		Nuclear (n = 211)		*t*	df	*p*	95% CI	
	M	*SD*	M	*SD*				LL	UL
TRM Total Score	4.08	.382	4.02	.442	1.440	397	.151	-.022	.142

Note. TRM-U = Trauma Recovery Measure Urdu Version; CI = confidence interval; LL = lower limit; UL = upper limit.

Table 8 presents family type comparisons on TRM-U scores.

Discussion

This study was designed to translate and validate TRM (TRM; Smith, 2022) in Urdu for Pakistani university students. Findings across all analyses were positive. The total scale showed acceptable reliability (alpha = .721), and exploratory factor analysis produced a three-factor solution closely matching the real instrument. Confirmatory factor analysis yielded excellent model fit across every index assessed. Composite reliability and convergent validity at the subscale level were both satisfactory.

A KMO index of .822 and a statistically significant Bartlett's test together supported that the responses were appropriate for factor analysis. Communalities across all 15 items ranged from .469 to .688, showing that every item shared a satisfactory proportion of variance with the extracted solution, and all 15 items were retained (Bibi & Kazmi, 2021). The rotated solution revealed a clearly defined three-factor structure in which every item loaded exclusively onto its theoretically designated subscale. Factor loadings exist from .684 to .829, all were above the minimum acceptable threshold of .35 (Field, 2009). No substantial cross-loadings were observed, confirming a simple factor structure. The three factors recovered, namely Validation, Liberation, and Positive Self, correspond precisely to those identified in Smith's (2022) original validation, demonstrating that the psychometric structure of the TRM has been successfully preserved in the Urdu adaptation.

The CFA results were exceptionally strong. A CMIN/DF of 1.056 closely approaches the ideal ratio of 1.0 and is well within the acceptable ceiling of 5 (Marsh & Hocevar, 1985; Marques et al., 2014). GFI (.971), AGFI (.960), CFI (.997), IFI (.999), and TLI (.996) all exceeded the optimum threshold of .90 (Hair et al., 2006). As Schumacher and Lomax (2010) noted, values approaching 1.0 on these indices represent near-perfect model specification. The RMSEA value of .012 was well below both the acceptable upper limit of .08 and the good-fit criterion of .05 (Hu & Bentler, 1999), and a PCLOSE value of 1.000 provided further confirmation of outstanding model fit. These results collectively rank among the strongest model fit statistics reported in Pakistani scale validation research, closely replicating the original English validation findings of Smith (2022).

Composite reliability (CR) and average variance extracted (AVE) were satisfactory for all three subscales. CR values for Validation (.878), Positive Self (.861), and Liberation (.865) all surpassed the minimum threshold of .60, and AVE values for Validation (.546), Positive Self (.507), and Liberation (.680) all met the recommended minimum of .50 (Fornell & Larcker, 1981; Hair et al., 2006). These results showed that the items of every subscale are consistently and accurately measuring their constructs.

Convergent validity fulfills the criteria as it showed a statistically significant positive correlation between TRM-U and SCS-SF scores ($r = .206$, $p < .05$), indicating that greater trauma recovery was associated with greater self-compassion. This value is close to the correlation of r = .25 that Smith (2022) reported between TRM and self-compassion in the original English sample and extends this finding to a Pakistani university context. This association is well documented in the literature, where self-compassion has consistently been shown to be negatively related to PTSD severity and positively associated with post-traumatic growth and resilience (Munroe et al., 2022; Valentino et al., 2025).

Data from the present study confirmed the divergent validity with the negative correlation between TRM-U and K10 scores (r = -.060), showing that psychological distress was lower as TRM-U scores were higher. The present study found that

this direction of relationship, as predicted with distress (r = - .60) has been corroborated with Smith (2022); however, the correlation coefficient was much smaller than in this previous study. This attenuation is most likely due to the lack of a large sub-sample (N = 100) for validity analyses and the individual natural variation in how many participants recovered in the study. It would be helpful to study this relationship further in future studies with larger sample sizes.

No significant gender differences or family types in TRM-U scores (t = 1.440, p = .151 and t = .388, p = .698, respectively). The results indicate that the scale is comparable across these population sub-groups, and that it can be applied generally to Pakistani university students without having to develop different norms for the various population sub-groups. The present sample was also diverse in terms of the types of traumas. Loved one's death experienced by its users was the most often reported experience (28.0%), followed by road traffic injury or illness (18.5%, physical injury or illness 17.0%, interpersonal violence 14.0% and natural disasters 12.0%, all other experiences 4.0%). These diverse trauma backgrounds also indicate that the TRM-U scores for recovery are similar across them.

The TRM was overall a valid and reliable instrument to measure the experience of trauma recovery for Pakistani university students in the Urdu language. The TRM-U presents a much-needed culturally and linguistically appropriate, recovery-focused, positive healing scale for clinicians, researchers, and practitioners that provides a measure of positive healing, not just symptom burden, which had never been available in Urdu before (Ahmer et al., 2007).

Conclusion and Implications

Finally, in conclusion, the Urdu translated version of the Trauma Recovery Measure was found a reliable and valid tool for measuring trauma recovery among Pakistani University students. The results of the factor analysis verified a pure three-factor structure as in the original scale, and confirmatory analysis had a good model fit. The SCS-SF attained sufficiently satisfactory scores for convergent validity, while divergent validity was supported by the score of the K10. No gender or family type differences were found, which implies good generalizability of the TRM-U in this population. A strength-based, culturally tailored assessment option is provided on the scale, which recognizes one of the existing gaps in the measurement of the mental health of Urdu speakers.

Restrictions and Suggestions for further research

Several restrictions of the current research were noted. The study's sample was limited to the convenience sampling of university students, thus restricting generalizability to other groups, including clinical patients, older adults, or those with lesser formal education. To conduct future research, more diverse and representative samples should be collected across a range of regions of Pakistan, including those currently in clinical trauma care.

Another drawback is that measurements used throughout the study were self-reports, which could also lead to social desirability bias. People who answer a so-called 'recovery' test might come across more positively than might be justified. Considering the use of self-report measures with clinician-administered assessment or the use of additional collateral material sources to provide a more comprehensive, objective data on participants' recovery status would be beneficial for future research.

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