

TRANSLATION OF THE COGNITIVE FAILURES QUESTIONNAIRE INTO URDU AND ITS RELIABILITY IN PAKISTANI WOMEN WITH POLYCYSTIC OVARY SYNDROME

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ABSTRACT

Small lapses of attention, memory and action are among the difficulties patients report most often, yet no Urdu instrument has been available for recording them. This paper reports an Urdu rendering of the Cognitive Failures Questionnaire (CFQ), published by Broadbent et al. (1982), together with an examination of how the translated items behave. Three bilingual translators wrote independent Urdu versions of the 25 items; a review panel settled on a single reconciled text; an English specialist who had never seen the source turned that text back into English; and the returned English was read against the original for agreement of sense rather than wording. The questionnaire was pre-tested and administered to 60 women carrying a gynaecological diagnosis of polycystic ovary syndrome in Punjab, aged 15 to 45 years ($M = 23.97$, $SD = 3.74$). The 25 Urdu items returned an alpha coefficient of .861, a mean inter-item correlation of .202 and a median corrected item-total correlation of .413, and 22 cleared the criterion of .30. The three that failed describe letter writing and road navigation, neither common among respondents of this kind; the weakest carried no information about the construct ($r = .021$) and held down its own subscale by a tenth. Totals rose with mental fatigue and fell with psychological well-being, and were unrelated to age, schooling, income, body mass index and time since diagnosis. The Urdu CFQ is recommended for use as a total score, with three items marked for revision.

I. INTRODUCTION

Most of what goes wrong with attention and memory in ordinary life goes wrong on a small scale. Someone forgets the errand that sent them upstairs, reads a page twice without taking it in, or picks up the wrong object while thinking about something else. Broadbent et al. (1982) proposed that the rate at which these slips occur is a characteristic of the person rather than an accident of the occasion, and built the Cognitive Failures Questionnaire around 25 concrete examples of them. Four decades of use have gone some way to bearing that proposal out. The measure resolves into several distinguishable components rather than one general factor (Wallace et al., 2002), and those components keep their meaning across the adult years (Rast et al., 2009). What gives the instrument its clinical interest is the company its scores keep. Broadbent et al. (1982) found that people reporting more frequent slips were also more vulnerable to stress, a result confirmed by Matthews et al. (1990) and later carried over to anxiety, fear and neuroticism (Hayati et al., 2023; Zufferey et al., 2017). Adults who described themselves as

forgetful rated their quality of life lower nine years afterwards (Mol et al., 2009), and a population study found that mild cognitive impairment raised the subsequent risk of depression and of anxiety (Mirza et al., 2016). Complaints of this sort are now taken seriously on their own account.

Subjective cognitive decline, where the person notices a change that standardised testing fails to register, is treated as a possible early signal (Si et al., 2020), and brain fog, the combination of unreliable concentration and memory, slowed processing and a sense of depletion, is described by patients across a wide span of conditions (Lucius, 2021; Ross et al., 2013), among them hypothyroidism (Samuels & Bernstein, 2022) and stroke (Johansson & Rönnbäck, 2012). Polycystic ovary syndrome belongs within that span. It is the commonest endocrine disorder of the reproductive years, and an estimated 65.77 million women of childbearing age were living with it in 2021 (Meng et al., 2025); a survey of adolescent girls across urban and rural Punjab returned a local figure of 26.7% (Aslam et al., 2025). Pakistani work has documented what the condition costs those women: anxiety in 20.3% and depression in 17.6% at an Islamabad teaching hospital (Tariq, 2024), quality of life falling further with each year since diagnosis among young women reporting depressive symptoms (Peerwani et al., 2023), and, in southern Punjab, a burden shaped as much by expectations about childbearing as by the disorder itself (Hassan et al., 2025). Reviews of cognition in affected women report measurable differences in performance and canvass androgen exposure, insulin resistance and low-grade inflammation as candidate mechanisms (Perović et al., 2022; Saei Ghare Naz et al., 2023), and free testosterone has been tied to particular cognitive functions in this group (Sukhapure et al., 2022).

Current guidance treats emotional well-being as part of routine care for the condition (Teede et al., 2023), and cognitive complaint sits beside low mood in the account patients give of it (Zahid & Javed, 2025). Recording that complaint requires an instrument the patient can read for herself. This is where practice in Pakistan runs short. Consultations are conducted in Urdu, and an English questionnaire handed to a patient is often answered only after somebody has interpreted it at the bedside, which inserts an unrecorded translator between the item and the response. The CFQ is more exposed to this than most measures, because its items are anecdotes rather than statements. Each sets out a small domestic incident that the reader has to recognise immediately and match against her own experience, and an item that has first to be worked out is no longer the item that was validated. Local versions of related instruments have begun to appear, among them Jibeen and Khalid's (2012) Urdu form of Ryff's well-being scales, an Urdu Neurological Fatigue Index for patients after stroke (Nazir et al., 2024), and an Urdu quality-of-life questionnaire for polycystic ovary syndrome validated on 180 Pakistani women (Zaman et al., 2024), but no Urdu CFQ existed when this work began. The present paper supplies one and reports its internal consistency, the behaviour of its individual items, and the way its scores relate to mental fatigue, to psychological well-being and to the characteristics of the respondents.

The Cognitive Failures Questionnaire (CFQ)

Broadbent et al. published the Cognitive Failures Questionnaire in the United Kingdom in 1982. It asks the respondent to think back over the previous six months and to say how often each of 25 named errors has happened to her. The errors are drawn from perception, from memory and from motor action, and they are put as incidents rather than as symptoms: a page read without being absorbed, an errand lost on the way to another room, a signpost missed, the wrong object thrown out and the right one kept, a word that will not come. Answers are given on five points, scored 0 for never, 1 for very rarely, 2 for occasionally, 3 for quite often and 4 for very often; the Urdu anchors are given in Appendix A. Summing the items gives a figure between 0 and 100, higher figures standing for more frequent failure. There is no cut-off, and the total is read as a continuous index. Rast et al. (2009) set out three subscales of eight items each, several items counting towards more than one: forgetfulness (items 1, 2, 5, 7, 17, 20, 22, 23), covering material known or intended and then lost; distractibility (items 8, 9, 10, 11, 14, 19, 21, 25), covering breaks in focused attention, mostly in company; and false triggering (items 2, 3, 5, 6, 12, 18, 23, 24), covering sequences of thought or movement that are interrupted or misdirected. Across published samples the English original has returned alpha coefficients between .75 and .94 (Volosin et al., 2023).

II. METHOD

Step 1: Preparation

Consent to render the CFQ in Urdu and to use it in this research was sought from its developer by electronic mail and granted in writing before any translation was attempted. A briefing document was then drawn up for the translators. For each of the 25 items it stated the behaviour the item is meant to capture and the sense in which particular English terms were to be read, and it specified the six-month window and the five-point answer format that the Urdu version had to keep. Circulating this document beforehand meant that the three translators started from one reading of the source instrument rather than from three private ones (Acquadro et al., 2008).

Formulation of the Expert Panel

Five people were involved. Three acted as forward translators: the researcher, a practising clinical psychologist, and an MSc student in clinical psychology. A fourth, a specialist in English with no part in the forward stage, acted as back translator. The academic supervisor, a lecturer in clinical psychology experienced in test adaptation, formed the reviewing pair with the researcher. All spoke Urdu as a first language, worked comfortably in English, knew both settings at first hand, and had a working acquaintance with the subject matter (Acquadro et al., 2008).

Step 2: Forward Translation

Each translator worked alone, with the English CFQ and the briefing document to hand, and produced a complete Urdu version of the 25 items and of the instruction text. The brief was to write Urdu that an ordinary reader would find unremarkable, preferring short and plain formulations to close tracking of the English (Acquadro et al., 2008). Since none of the three saw what the others were doing, the next stage received three separate readings of every item rather than three edits of one.

Step 3: Reconciliation

The panel then went through the instrument, holding each of the three Urdu renderings against its English source. Four questions were put to every candidate wording, following Beaton et al. (2000): whether it carried the same meaning, whether its idiom would be recognised by Urdu readers, whether the situation it describes is one those readers could have lived through, and whether the underlying concept survived the move between the two settings. The supervisor and the researcher recorded a judgement on each item independently before comparing notes. A draft that answered all four questions was adopted; where none did, a fourth wording was written. Disagreements were settled in discussion, and anything left open was decided by the supervisor. What came out of this stage was a single reconciled Urdu draft (Acquadro et al., 2008).

Step 4: Back Translation

That draft went to the specialist in English, who had taken no part in producing it and who worked without sight of the 1982 questionnaire. The task was to write in English what the Urdu said. The exercise was not a judgement on the quality of the Urdu; its purpose was to expose any item whose meaning had moved during translation (Acquadro et al., 2008).

Step 5: Back-Translation Review

The researcher and the supervisor placed the back translation next to the English original and read the two in parallel. Differences of wording were passed over; differences of sense were not. Where the returned English described something other than the source item, the Urdu was reworked, and substantive changes went back to the panel. The version that emerged was taken as final (Acquadro et al., 2008). It keeps the six-month reference period and the instruction to circle one number for each item, and its five anchors are those reproduced in Appendix A.

Step 6: Pre-testing

The final draft was tried out ahead of the main administration, to establish that the instructions, the items and the answer anchors were being understood as intended. The wording was settled on the strength of that trial, and the questionnaire whose properties are reported below is the one it produced.

Step 7: Full Study

Participants

Sixty women took part, each holding a gynaecologist's diagnosis of polycystic ovary syndrome made against the criteria of the National Institute of Child Health and Human Development. They were approached at private and government hospitals and clinics across Punjab by purposive, non-probability sampling. Their ages ran from 15 to 45 years and averaged 23.97 years ($SD = 3.74$). Excluded were women whose condition had resolved, and any woman carrying a further psychiatric diagnosis or another medical condition such as endometriosis, type 2 diabetes, cardiovascular disease or hypertension. These data were gathered within a larger project on cognitive and fatigue-related complaint in polycystic ovary syndrome, and the same participants are described in a companion paper reporting the Urdu translation of the Mental Fatigue Scale.

Measures

An Urdu demographic form recorded age, schooling, occupation, household income, birth order, marital status, children, locality, family structure, menstrual regularity, height, weight and body mass index, the year of diagnosis, time since then, time in treatment and the facility attended. Two further instruments accompanied the Urdu CFQ. The Mental Fatigue Scale (Johansson et al., 2010) covers 14 scored aspects of mental fatigue on anchors from 0 to 3, and was used in an Urdu version prepared by the researcher through the procedure set out above ($\alpha = .852$ here). Psychological well-being was measured with the 54-item form of Ryff's scales (Ryff, 1989) in the Urdu translation of Jibeen and Khalid (2012), used by permission of the author and the translators ($\alpha = .857$).

Procedure

Approval to approach patients was obtained from the managements of the participating hospitals and clinics in Punjab. Every participant was told what taking part would involve before she agreed to it, and each gave written consent in the knowledge that her answers would carry nothing identifying her and that she was free to decline or to withdraw at any point without consequence. Participants under 18 years of age gave their own assent, and written consent was obtained in every such case from a parent or guardian. Nothing in the procedure placed any participant at physical or psychological risk. Consent to translate the Cognitive Failures Questionnaire into Urdu and to use it in this research was obtained in writing from its developer before any translation was attempted. Ryff's Scales of Psychological Well-Being were administered in the Urdu translation of Jibeen and Khalid (2012), with the permission of the author of the original scales and of the translator.

III. RESULTS

Table I: Descriptive Statistics for the Urdu CFQ and its Subscales (N = 60)

Scales	No. of Items	Minimum	Maximum	Mean	Variance	Std. Deviation
Cognitive Failures Questionnaire (Urdu)	25	20	82	51.73	225.90	15.03
Forgetfulness	8	4	27	17.47	31.58	5.62
Distractibility	8	6	27	18.02	29.92	5.47
False Triggering	8	3	27	14.12	33.06	5.75

Note. Several items count towards more than one subscale, so the subscale item counts do not sum to 25.

Table 1 reports how the scores were distributed. Against a possible 0 to 100, observed totals ran from 20 to 82 about a mean of 51.73 ($SD = 15.03$). Neither end of the scale was reached by anyone, and the observed spread covered enough of the available range to separate respondents from one another without bunching at the floor or the ceiling. Each subscale can reach 32; forgetfulness averaged 17.47, distractibility 18.02 and false triggering 14.12. The respondents were young, urban and comparatively well-schooled. Their ages averaged 23.97 years ($SD = 3.74$) within a range of 15 to 45. Forty-three (71.7%) had reached undergraduate level and 11 (18.3%) were graduates, the remaining six having stopped at intermediate ($n = 3$, 5.0%), middle school ($n = 2$, 3.3%) or matriculation ($n = 1$, 1.7%). Thirty were students (50.0%), 13 single and in work (21.7%), nine married and in work (15.0%), five married and not working (8.3%) and three single and not working (5.0%). Forty-two (70.0%) were married, yet 53 (88.3%) had no children, five had one (8.3%) and two had two (3.3%). Monthly household income averaged PKR 134,283.33 ($SD = 95,705.95$), spread evenly between the middle ($n = 23$, 38.3%) and upper middle

bands ($n = 23$, 38.3%) with 14 families (23.3%) in the high band. Twenty-two were firstborn (36.7%), 15 second (25.0%), 13 third (21.7%), eight fourth (13.3%) and two fifth (3.3%).

Fifty-three lived in urban areas (88.3%), 36 in nuclear households (60.0%) and 24 in joint ones (40.0%). Clinically, 47 women (78.3%) reported irregular cycles and 13 (21.7%) regular ones. Mean weight was 63.85 kg ($SD = 13.97$) and mean height 161.20 cm ($SD = 6.34$), placing 28 (46.7%) in the healthy range of body mass index (18.5–24.9), 17 (28.3%) overweight (25.0–29.9), nine (15.0%) obese (≥ 30) and six (10.0%) underweight (< 18.5). Thirty-nine attended private facilities (65.0%) and 21 government ones (35.0%). Diagnosis had been made on average 3.86 years earlier ($SD = 3.32$), for 35 women within the preceding three years (58.3%), for 16 between three and six years (26.7%), for six between six and nine (10.0%) and for three between twelve and fifteen (5.0%). Treatment had been running for an average of 2.05 years ($SD = 2.06$), up to three years for 49 women (81.7%), three to six for seven (11.7%) and six to nine for four (6.7%).

Table II: Item Analysis of the Urdu CFQ (N = 60)

Item	Content	<i>M</i>	<i>SD</i>	Scale means if item deleted	Corrected item-total correlation	Alpha if item deleted
CFQ1	Reading without attending to the content	2.73	0.94	49.00	.416	.856
CFQ2	Forgetting the purpose of moving about the house	2.10	1.41	49.63	.421	.856
CFQ3	Failing to notice signposts on the road	1.47	1.33	50.26	.235 ^a	.862
CFQ4	Confusing right and left when giving directions	2.35	1.15	49.38	.484	.854
CFQ5	Bumping into people	1.98	1.28	49.75	.389	.857
CFQ6	Forgetting whether a light or a door was attended to	1.85	1.33	49.88	.455	.855
CFQ7	Failing to attend to names on being introduced	2.15	1.29	49.58	.535	.852
CFQ8	Saying something that may be taken as insulting	2.27	1.18	49.46	.419	.856
CFQ9	Failing to hear others while occupied	2.30	1.34	49.43	.594	.850
CFQ10	Losing temper and regretting it	2.40	1.36	49.33	.399	.857
CFQ11	Leaving important letters unanswered	2.05	1.35	49.68	.021 ^a	.869
CFQ12	Forgetting the turning on a familiar but rarely used road	1.52	1.20	50.21	.290 ^a	.860
CFQ13	Failing to find a wanted item in a shop	1.57	1.21	50.16	.473	.854
CFQ14	Doubting the correct use of a word	2.30	1.21	49.43	.449	.855
CFQ15	Difficulty in making up one's mind	2.55	1.20	49.18	.463	.855
CFQ16	Forgetting appointments	1.53	1.35	50.20	.376	.857
CFQ17	Forgetting where an object was placed	2.17	1.18	49.56	.385	.857
CFQ18	Discarding the wanted object and keeping the other	1.58	1.27	50.15	.625	.849
CFQ19	Daydreaming when listening is required	2.27	1.26	49.46	.342	.858
CFQ20	Forgetting people's names	2.20	1.29	49.53	.385	.857
CFQ21	Starting one task and drifting into another	2.25	1.16	49.48	.402	.856
CFQ22	Being unable to recall a word on the tip of the tongue	2.35	1.15	49.38	.640	.849
CFQ23	Forgetting what was to be bought	1.78	1.15	49.95	.403	.856
CFQ24	Dropping things	1.83	1.36	49.90	.408	.856
CFQ25	Being unable to think of anything to say	2.18	1.27	49.55	.413	.856

Note. The coefficient for the complete 25-item scale is .861. Corrected item-total correlation below the criterion of .30.

Internal consistency was assessed with Cronbach's alpha, which expresses the degree to which the items of a scale behave as measures of one thing. Coefficients close to unity indicate items that move together, and low coefficients indicate items that do not. Fraenkel and Wallen (1996) regard values between .70 and .99 as acceptable. For the 25 Urdu items the coefficient was .861, comfortably inside that band and inside the .75 to .94 span that published studies of the English original have produced (Volosin et al., 2023). The subscales returned .714 for forgetfulness, .680 for false triggering and .652 for distractibility. Coefficients of that size are unremarkable for scales of eight items, since the value of alpha depends in part on how many items are being averaged, and for short scales the mean inter-item correlations set out in Table 3 are the more informative figures. Table 2 gives the item statistics. Corrected item-total correlations spanned .021 to .640 with a median of .413, and 22 of the 25 items cleared .30, the value ordinarily taken to mark an item that is doing its job (Nunnally & Bernstein, 1994). The strongest were CFQ22, on the word that will not come (.640), CFQ18, on discarding the wrong object (.625), and CFQ9, on not hearing someone while occupied (.594). Three items failed: CFQ11, on unanswered letters (.021), CFQ3, on missed signposts (.235), and CFQ12, on the wrong turning on a familiar road (.290). Alpha with an item deleted varied between .849 and .869. Only the removal of CFQ11 would have made any appreciable difference, gaining .008; no other deletion would have gained more than .001, and most would have cost reliability.

Table III: Coefficients and Mean Inter-Item Correlations for the Urdu CFQ (N = 60)

Scale	No. of Items	Cronbach's Alpha	Mean Inter-Item Correlation
CFQ Total	25	.861	.202
Forgetfulness	8	.714	.242
Distractibility	8	.652	.196
False Triggering	8	.680	.211
CFQ Total without item 11	24	.869	.218
Distractibility without item 11	7	.752	.304

Table 3 sets the alpha coefficients beside the mean inter-item correlations. Across the full scale the items correlated on average at .202, which falls inside the interval of .15 to .50 that Clark and Watson (1995) recommend for instruments covering a broad domain: high enough for the items to belong together, low enough that they are not saying the same thing twice over. Subscale averages were .242 for forgetfulness, .196 for distractibility and .211 for false triggering. A surprising amount of what these subscale figures show is attributable to CFQ11. Taken out of distractibility, it lifts that subscale from .652 to .752 and its average inter-item correlation from .196 to .304, turning the weakest of the three into the strongest, and it lifts the full-scale coefficient from .861 to .869. Scoring for the present analysis nevertheless used all 25 items, so that Urdu totals stay on the same footing as those of the source instrument.

Table IV: Correlations of the Urdu CFQ with Mental Fatigue and Psychological Well-Being (N = 60)

Variable	Forgetfulness	Distractibility	False Triggering	CFQ Total
Mental Fatigue Scale	.358**	.351**	.434***	.460***
Psychological Well-Being (total)	-.245	-.323*	-.359**	-.423***
Autonomy	.111	-.051	-.041	-.033
Environmental Mastery	-.237	-.345**	-.319*	-.421***
Personal Growth	-.014	.031	-.072	-.042
Positive Relations with Others	-.514***	-.512***	-.457***	-.578***
Purpose in Life	-.128	-.159	-.272*	-.298*
Self-Acceptance	-.302*	-.400**	-.397**	-.484***

Note. * $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4 sets the Urdu CFQ against the two comparison instruments. Reported cognitive failure rose as mental fatigue rose and fell as psychological well-being rose, in both cases by an amount appropriate to constructs that are related without being interchangeable. The well-being result was selective rather than uniform. Totals tracked positive relations with others most closely, then self-acceptance, environmental mastery and purpose in life, while autonomy and personal growth were left untouched. The subscales followed the same order, though not every

coefficient reached significance: positive relations with others and self-acceptance were significant for all three, environmental mastery for distractibility and false triggering, and purpose in life for false triggering alone.

IV.DISCUSSION

This paper set out to produce an Urdu CFQ and to establish how it behaves. The translation followed the sequence recommended by Acquadro et al. (2008): three independent forward versions, a documented reconciliation, a blind back translation, a reading of the returned English against the source, and a pre-test. Nazir et al. (2024) and Zaman et al. (2024) worked to the same specification in adapting other instruments into Urdu. The findings divide in two. The scale as a whole came through the process in good order. Three of its items did not. At scale level the evidence is straightforward. The coefficient of .861 sits within the range published for the English original (Volosin et al., 2023), scores occupied 20 to 82 of the available 100 rather than clustering, and an average inter-item correlation of .202 shows that the coefficient rests on real association among the items and not merely on there being 25 of them. Item by item, 22 of the 25 met the usual criterion, and a median correlation of .413 is respectable for a measure of this breadth. The three exceptions have something in common that a summary statistic would have concealed. Each describes an activity that a young, urban Pakistani woman is unlikely to undertake. CFQ11 asks how often important letters go unanswered for days, and personal correspondence by letter has all but disappeared. CFQ3 and CFQ12 are both about driving, one concerning signpost and the other a turning on a road that is known but seldom used, and driving is far less common among women in this population than in the British sample the questionnaire was written for.

CFQ11 shows the difficulty in its purest form. A correlation of .021 with the remainder of the scale means the item said nothing at all about the construct in this sample, and taking it out lifted the coefficient of its own subscale by a full tenth. The reason is not obscure. A woman who writes no letters cannot fail to answer them, so her response reports the absence of the occasion rather than the presence of a cognitive failure. What has broken down is cultural equivalence, not linguistic equivalence, and back translation is structurally incapable of catching it. Given a faithful Urdu item about letters, a back translator returns a faithful English item about letters, and the reviewing pair finds no discrepancy because there is none to find. Only administering the questionnaire and reading the item statistics brought it to light. The three items were kept in the present scoring, since dropping any of them would have changed the range of the total and broken comparability with the original, but their Urdu wording ought to be revisited before the instrument is used more widely. The correlations with the two comparison measures point the same way as the reliability evidence. Cognitive failure rose with mental fatigue and fell with psychological well-being, by amounts that neither collapse the constructs together nor leave them unconnected. The well-being correlations are the more telling, because they were selective. Had the translated items degenerated into a general report of feeling unwell, every dimension of well-being would have moved with them.

Instead, the association concentrated on positive relations with others, self-acceptance, environmental mastery and purpose in life, the dimensions that depend on dealing with other people and running one's daily affairs, and vanished for autonomy and personal growth, which do not. Broadbent et al. (1982) argued at the outset that cognitive failure has a bearing on mental health, and the literature since has connected it to stress, anxiety and neuroticism (Hayati et al., 2023; Matthews et al., 1990; Zufferey et al., 2017). The present data carry that connection into an Urdu-speaking sample. What the paper adds is a systematically translated Urdu measure of everyday cognitive failure to a literature that has had none, and with it a means of recording complaints that Pakistani clinicians hear regularly and have so far had to note in prose. Several qualifications apply. Sixty respondents are too few to support a factor analysis, so nothing can be said here about whether the three-subscale structure of the English scoring key survives translation, and the subscale figures reported above should be read with that in mind. Stability over time was not examined, which leaves test-retest reliability the most obvious gap in the evidence. Participants were recruited purposively from treatment-seeking women in one province and were mostly urban and educated, so these coefficients cannot be assumed to hold for men, for older women, for rural or less-schooled respondents, or for the population at large. No objective test of cognitive performance was given, so how the translated self-report relates to measured cognition remains open, and because both comparison instruments were themselves self-report measures, one of them translated for this

same study, shared method variance will have inflated the correlations in Table 4 by an unknown amount. Larger and more varied samples are needed to settle the factor structure, to estimate stability and to establish criterion validity.

Implications

The Urdu CFQ is offered to clinical psychologists, gynaecologists, neurologists and researchers who need a record of everyday cognitive difficulty in Urdu-speaking patients, whatever the presenting condition. It takes a few minutes, needs neither equipment nor a trained administrator, and can be completed in a waiting area, which suits services where formal neuropsychological assessment is out of reach. Until the factor structure has been examined in an adequate sample, the total is the figure to report. Three changes are recommended. CFQ11 should be rewritten around a situation respondents in Pakistan actually meet, such as leaving a message unanswered for several days. CFQ3 and CFQ12 should be recast so that they do not presuppose driving, or reserved for samples in which women drive. Beyond these particulars the item-level results carry a general point. Forward and back translation can establish that two texts mean the same thing; they cannot establish that the situations described occur in both settings. Where an instrument was built around the daily life of one population, item analysis in the receiving population is part of the translation, not an optional sequel to it.

V. CONCLUSION

The Cognitive Failures Questionnaire now exists in Urdu, produced through a documented sequence of independent forward translation, panel reconciliation, blind back translation, review and pre-testing, and administered to 60 Pakistani women with polycystic ovary syndrome. Its 25 items returned a coefficient of .861, 22 met the conventional item-total criterion, and totals related to mental fatigue and to psychological well-being in the directions and with the selectivity a sound translation would be expected to produce. Three items, on letter correspondence and road navigation, failed because the situations they describe are uncommon in this population, not because their Urdu is inaccurate. Subject to revision of those three items, and to confirmation of its structure in a larger sample, the total score of the Urdu CFQ is fit for research and clinical use with Urdu-speaking respondents.

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