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The significance of exploring conceptual equivalence within the process of the cross-cultural adaptation of tools: The case of the Patient's Perception of Feeling Known by their Nurses Scale

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Abstract

Introduction: The exploration of conceptual equivalence within the process of the cross-cultural adaptation of tools is usually neglected as it generally assumed that the theoretical construct of a tool is conceptualized in the same way in both the original and target culture. This article attempts to throw light on the contribution of the evaluation of conceptual equivalence to the process of adaptation, and for tool development. To illustrate this premise, the example of the cross-cultural adaptation of the Patients' Perception of Feeling Known by their Nurses (PPFKN) Scale is presented.

Design: An adapted version of the Sousa and Rojjanasrirat (*Journal of Evaluation in Clinical Practice*, 2011, 17(2), 268–274) guidelines was used to translate and culturally adapt the PPFKN Scale to Spanish language and culture. A qualitative descriptive study was added to the traditional process of translation and pilot study to explore the concept in the target culture and recognize conceptual equivalence.

Methods: Experts in the tool concept, bilingual translators and the author of the tool participated in the translation of the original tool into Spanish. A pilot study of the Spanish version with a sample of 44 patients and a panel of six experts from different fields evaluated its clarity and relevance. In addition, seven patients participated in a descriptive qualitative study using semi-structured individual interviews to explore the phenomenon in the new culture. A content analysis following the Miles, Huberman & Saldaña (Qualitative data analysis, a methods sourcebook, 2014) approach was used to analyze qualitative data.

Results: The cross-cultural translation and adaptation of the PPFKN scale into Spanish required a thorough revision. More than half of the items needed discussions to reach consensus regarding the most appropriate Spanish term. In addition, the study confirmed the four attributes of the concept identified in the American context and allowed for new insights within those attributes to appear. Those aspects reflected

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characteristics of the phenomenon of being known in the Spanish context and were added to the tool in the format of 10 new items.

Conclusions: A comprehensive cross-cultural adaptation of tools should incorporate, together with the study of linguistic and semantic equivalence, the analysis of the conceptual equivalence of the phenomenon in both contexts. The identification, acknowledgment and study of the conceptual differences between two cultures in relation to a phenomenon becomes an opportunity for deeper study of the phenomenon in both cultures, for understanding of their richness and depth, and for the proposal of changes that may enhance the content validity of the tool.

Clinical relevance: The evaluation of conceptual equivalence of tools within the process of cross-cultural adaptation will make it possible for target cultures to rely on tools both theoretically sound and significant. Specifically, the cross-cultural adaptation of the PPFKN scale has facilitated the design of a Spanish version of the tool that is linguistically, semantically and theoretically congruent with Spanish culture. The PPFKN Scale is a powerful indicator that evidences nursing care contribution to the patient's experience.

KEYWORDS
conceptual equivalence, cross-cultural adaptation, knowing the patient, qualitative research, scales, tools, translation

INTRODUCTION

It is important for the nursing profession to have tools that measure phenomena that are relevant to the discipline (Fawcett & DeSanto-Madeya, 2012). These tools provide the operationalization of these phenomena and therefore facilitate their development in practice.

Tools are usually developed in the context of a specific culture and language but in order to be used internationally their suitability and relevance in the target culture is indispensable (Acquadro et al., 2018; Herdman et al., 1997; Prakash et al., 2019; Sidani et al., 2010).

In the present global context, it is especially relevant to have tools that can be used on a wide scale to allow research with international scope to be carried out. To count on cross-culturally validated tools allows data to be gathered from different populations, countries and languages and therefore increases the validity and generalizability of the studies conducted (Rabin et al., 2014; Sousa & Rojjanasrirat, 2011; Wild et al., 2005).

Different strategies and methods can be used to obtain a version of the tool that is faithful to the original not only in terms of language and meaning, but also in terms of the concept being studied. Guidelines to orient this complex process have been developed based on literature reviews, research experience in the field and expert discussion. Some examples are the work of Guillemin et al. (1993), Wild et al. (2005), Sousa and Rojjanasrirat (2011) or Acquadro et al. (2018). According to these authors, when a multistep rigorous process is used, there are greater guarantees that the adapted tool will be culturally competent.

However, authors with recognized expertise on the cross-cultural translation of instruments such as Herdman et al. (1998), Prakash et al. (2019) and Regnault and Herdman (2015) advise that most of the cross-cultural adaptation guidelines assume that the theoretical construct of a tool is conceptualized similarly in both cultures and that therefore a semantic and linguistic adaptation suffices. According to them, concepts are culturally dependent and therefore it cannot be assumed that those concepts will behave similarly in different contexts. Therefore, they advocate for a culturally sound translation which implies a clear understanding of the theoretical construct of the tool in both the source and the target culture, as well as the intricacies of cultural differences between the two cultures. This is particularly relevant when working on the translation of abstract constructs such as patients' experiences, perceptions or expectations, which are usually influenced by cultural aspects and therefore more likely to be conceptualized differently in diverse cultures.

The study of conceptual equivalence should include a thorough investigation of the extent to which the instrument evaluates the underlying phenomenon and the parameters of the latent trait in the target culture as well as it did in the source culture (Herdman et al., 1998; Prakash et al., 2019). Conceptual equivalence is achieved when the tool has the same relationship to the underlying concept regarding the attributes and the emphasis placed on each in both cultures (Herdman et al., 1998). In order to assess that equivalence, Prakash et al. (2019) suggest the use of cognitive interviews and focus groups with stakeholders, patients, clinicians and experts on the construct. Herdman et al. (1998) go even further and indicate

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that researchers should conduct a thorough investigation including literature reviews of the concept in the target culture, examination of existing tools related to the concept, interviews with experts on the concept and some type of qualitative work.

An important issue arising from the evaluation of conceptual equivalence is how to handle the lack of equivalence if the domains in the target culture are not the same as in the source culture. Herdman et al. (1998) advocate for a universalistic approach. This approach aims to identify the aspects of a concept that are universal across cultures and use only these when translating and adapting tools. Prakash et al. (2019) together with Herdman et al. (1998) indicate that if prospects of cross-cultural adaptation producing a culturally equivalent measure are significantly limited, then the development and validation of a new instrument within the context of the target culture should be considered necessary and unavoidable.

Authors such as Sidani et al. (2010) advocate for a more integrative approach for the cultural adaptation of tools, that is, to recognize the differences in the conceptualization of a concept between cultures, and to acknowledge them by modifying, adding or eliminating items in the translated tool. They emphasize that the tool should reflect both the common aspects across cultures as well as the specific ones of a particular culture although this may limit cross-cultural comparison. These authors advocate for investigating alternative approaches for conceptualizing and examining cross-cultural measurement.

The present study attempts to throw light on how the examination of conceptual equivalence can be carried out and what some of the implications for tool development are. The assumption is that evaluation of the concept in the target culture can become a source for the enrichment and further development of original tools. To illustrate this premise, an example will be provided, that is, the translation and cultural adaption to Spanish of the Patients' Perception of Feeling Know by their Nurses (PPFKN) Scale. The PPFKN tool developed by Somerville in English in the USA (2009a, 2009b) represents one of the first attempts to measure the quality of the nurse–patient relationship from the patients' experience. The particularities of the translation and cultural adaptation of the PPFKN Scale are suitable for the general purpose of this article which is mainly methodological and related to the cross-cultural adaptation of tools. The fact of using the PPFKN as an example can be useful given that the tool itself and the concept it represents is central for the nursing profession.

The PPFKN Scale and its theoretical framework

According to contemporary authors, the central focus of nursing is the interpersonal nurse–patient relationship (Jones, 2013; Newman et al., 2008; Olano-Lizarraga et al., 2021). This relationship is embedded in a partnership that facilitates the sharing of knowledge and creates an environment for the discussion and validation of patients'/families' experiences (Jones, 2013; Newman et al., 2008). This approach implies the recognition of patients as unique beings and uses this as a basis to work with them towards their global well-being. In such a situation, understanding the patient is paramount (Saracíbar, 2009). Research on the phenomenon of knowing the patient is still scarce and focuses mainly on the aspects such as its impact on nurses' clinical judgment and decision-making, and on the individualization of, and satisfaction with, care (Osácar, 2018; Pereira-Sánchez & Zaragoza-Salcedo, 2020). New research is being developed which examines the impact of knowing the patient on their experience of care. In this sense, Somerville's (2009b) study on patients' perception of being known and understood brings new light into that unexplored area. Based on a literature review and a qualitative study conducted in a highly specialized American hospital, she found that the phenomenon of feeling known by their nurses included four attributes: experience of a meaningful and personal connection with their nurses; being recognized as unique human beings; feeling safe; and feeling empowered by the nurses to participate in their own care. As a consequence of the study, Somerville (2009a) developed a valid and reliable self-administered scale with 48 items made up of four factors to be used in a population of hospitalized patients' in general medical–surgical wards.

The translation and adaptation process of the PPFKN Scale was promoted by a Spanish nursing scientists research group, working under the "Model of the Interpersonal Relationship between the Nurse and the Person/Family Care for" developed by Saracíbar (2009). The conceptual bases of the model, which are described in Olano-Lizarraga et al. (2022), share values and principles similar to the conceptual framework of Somerville's (2009b) scale. Among other key elements, it includes the conceptualization of nursing as an interpersonal relationship which includes knowing the patient as one of its principal elements. Use of scales such as the PPFKN will help to make essential aspects of nursing care detectable and measurable. On this basis, potential research can be directed to understand factors that enhance or complicate the patients' feeling of being known, together with interventions that may enrich that perception. Given the significance of the above-mentioned research and the use of Spanish worldwide, it was decided to construct the Spanish version of this tool.

DESIGN

The present study aims to throw light on how the examination of conceptual equivalence can be carried out within the process of the cross-cultural adaptation of tools and how it can contribute to tool development. For this purpose, the translation and adaptation of the PPFKN Scale to the Spanish language and culture is presented.

A modified version of the Sousa and Rojjanasrirat (2011) guidelines for the translation and cultural adaptation of tools was selected given the relevance it has in both cultures (original and target), and its ease of use. The guide includes forward and back translations, the use of committee approaches to resolve ambiguities, discrepancies and to reach synthesis, pilot studies and psychometric testing (see Table 1).

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TABLE 1 Sousa et Rojjanasrirat Guidelines (2011).

Step 1	Translations of the original instrument into the target language (forward translation or one-way translation)
Step 2	*Comparison of the two translated versions of the instrument: Synthesis 1*
Step 3	*Blind Back translations of the preliminary initial translated version of the instrument*
Step 4	Comparison of the two back-translated versions of the instrument: Synthesis 2
Step 5	Pilot testing of the pre-final version of the instrument in the target language with a monolingual sample: cognitive debriefing
Step 6	Preliminary psychometric testing of the pre-final version of the translated instrument with a bilingual sample
Step 7	Full psychometric testing of the pre-final version of the translated instrument in a sample of the target population

On the basis of the Sousa and Rojjanasrirat (2011) guidelines, two main actions were undertaken following the suggestions of Herdman et al. (1998) to evaluate the conceptual equivalence of the scale. On the one hand, to incorporate experts on the phenomenon within the planned committees for Synthesis I and II. Those experts were members of the research group 'Innovation for Patient-Centered Care'. On the other hand, to include a qualitative study to explore patients' perception of feeling known in the Spanish context.

Therefore, the final version of the guide as used in the present study included two main phases: Phase 1, consisting of the translation and cultural adaptation of the scale and included steps 1–5 of Sousa & Rojjanasrirat's guidelines and Phase 2, which included a qualitative descriptive study (new step).

In accordance with the main purpose of the study, psychometric evaluation is not included in this article.

MATERIALS AND METHODS

The study was conducted in a private 300-bed tertiary teaching hospital in the north of Spain. It is a highly specialized center attending patients in all specialties who come from different Spanish regions. The center has a commitment to deliver patient-centered care. The ethos of institution is based on the principles of Cristian humanism. The study received ethical approval from the Ethical Committee of the institution where the study was undertaken, and it conforms to the standards of the World Medical Association Declaration of Helsinki (World Medical Association, 2022).

Phase 1. Translation and cultural adaptation of the scale

The process followed for the translation of the tool is represented in Figure 1. First, two forward translations of the PPFKN Scale (T1, T2) including instructions, items and response terms were

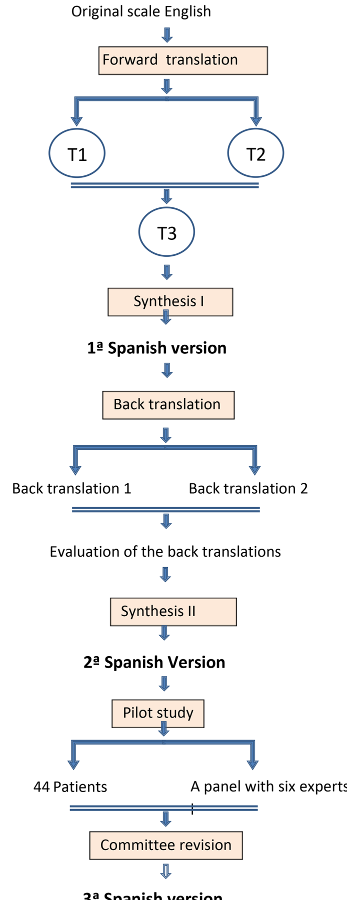

FIGURE 1 Phase 1: The translation and cultural adaptation of PPFKN scale to Spanish.

independently developed by two official translators whose mother tongue was Spanish. A third independent translator compared both translations and proposed a new one (T3). The three versions were reviewed by a committee composed by the three translators and four experts belonging to the research group 'Innovation for Patient-Centered Care', based on Saracíbar's (2009) Conceptual Model. The aim of the committee was to analyze and discuss discrepancies in terms, sentences or meaning, and reach consensus (Synthesis I).

The first translated version of the tool was then back translated independently by two translators whose mother tongue was English. Those translations were blind as the translators had not previously seen the original version. The two back translations were reviewed by a committee made up of the two back translators, one forward translator, three experts from the research group 'Innovation for Patient-Centered Care' and the author of the original scale. Discrepancies were discussed to reach consensus. When necessary, the author of the scale clarified the meaning of the items. As a result of Synthesis II, a new version was obtained.

The pilot study of the second version of the translated tool was carried out with a convenience sample of 44 adult patients from two medical–surgical wards. Inclusion criteria included patients of legal age, with full cognitive abilities, who had expressed their agreement to participate in the study and were about to

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be discharged in the following 24h. Access to the patients was through the unit supervisors. Candidate patients were approached by the researcher who was not related to the unit and to the patients in any way. The researcher explained the study to the patient, highlighting that the questionnaire would be answered anonymously and that they could withdraw from the study at any time without any repercussion on their care in any way. In addition to the oral explanation, they were also given written information about the study. Those who agreed to participate were asked to sign the informed consent form.

In addition to the sample of patients, a panel of six professionals from academia and the healthcare field, with knowledge of the study phenomenon, participated in the evaluation of the tool.

The patients´ and professionals´ participation consisted of giving their opinion regarding the clarity of each of the items of the translated version of the tool by rating each scale item, including response options and questionnaire instructions as "clear" or "not clear, and in the "not clear" case providing an alternative. In addition, the professionals indicated the relevance of each item through a Likert scale from 1 to 4. To conclude, a committee formed by researchers and experts from the research group made the final decisions based on the results of the translation of the tool, thus obtaining the third version of the tool.

Phase 2. A qualitative descriptive study

In addition to the exhaustive process followed in Phase 1 to translate and culturally adapt the PPFKN Scale to Spanish language and culture, a qualitative descriptive study using semi-structured interviews was conducted following the recommendations of Herdman et al. (1998) for the study of conceptual equivalence in the target culture. The aim was to further analyze the patient's perception of being known in the Spanish context and confirm the presence of the four attributes of the concept identified in the North American context, and to bear in mind new culturally relevant information which might appear.

A convenience sampling was used to select patients who could provide information regarding the subject of study. A sample size of seven patients was considered appropriate given the recommendations of Regnault and Herdman (2015) for cognitive debriefings. The inclusion criteria included having spent at least 48h in a medial or surgical ward, being a Spanish national, of legal age, with the capacity to be interviewed and having expressed agreement to participate.

Nurses from the study wards were informed about the study as they were the gatekeepers for identifying possible study patients. One of the researchers from the research group, working at the hospital in a different unit from those of the study, approached the potential participants and invited them to participate in the study. Oral information about the study was given to the patients, including the codification of data to assure confidentiality and the fact they could leave the study at any time with no repercussions whatsoever on their care. Patients were then given a written information sheet and, if they agreed to participate, were asked to sign the informed consent form.

Semi-structured interviews took place in the patients' rooms in a context of trust to facilitate patients' sharing of experiences. The interview guide was developed based on a literature review on the phenomenon (Osácar, 2018) and the schedule used in the original study. The guide was reviewed by three nurse researchers conversant with the area of knowing the patient. The questions were broad and open ended. Examples are included in Table 2. The researcher who conducted the interviews encoded the identities of the participants, and no other members of the team had access to patient information identification.

The interviews were transcribed verbatim and analyzed following the Miles et al. (2014) content analysis approach. The aim of the analysis was to describe the phenomenon of the patient's perception of being known by their nurses in a Spanish context. Two researchers analyzed the interviews independently. Meetings were held after the analysis of each interview to discuss the codes identified and reach consensus. Definitions were elaborated for complex codes. At a second stage, the researchers sought relationships among the codes, merging them in accordance with common aspects and developing broader categories in this way. During this stage, a greater degree of interpretation took place (Miles et al., 2014). The evolution from codes to categories and finally from categories to themes was oriented by the conceptual framework of the study, the nurse–patient interpersonal relationship, together with a previously conducted literature review (Osácar, 2018). The researchers maintained a critical and reflexive approach throughout the analysis process to detect any differences relating to the perception of being known with the original study. Once the main themes and categories were identified they were matched with the four attributes of the original study to detect similitudes and differences.

RESULTS

This section presents the results from each phase of the study concisely, including the evaluation of the conceptual equivalence.

Phase 1: The translation and cultural adaptation of the scale

The most relevant results from the translation and cultural adaptation of the scale are presented following the main steps of the process: forward translation, back translation and pilot study (Figure 1).

TABLE 2 Semi-structured Interview guide.

What has your experience in relation to nursing care been like?
Which things are important to you when being cared for by the nurse?
In what way have these things been present in the care received?
What aspects do you think are important that your nurse should know when caring for you? Why? Do you think that those aspects have been important for the nurse?

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The three forward translations versions (T1, T2 and T3) were reviewed by a committee made up of translators and experts. The presence of the experts was relevant to provide context in relation to the theoretical background of the scale. For instance, the three forward translators chose the article '**the**' nurses to translate '**my**' nurses. Nevertheless, the experts clarified that the scale referred to the nurses looking after the patient in that admission and not to all of them in general. Therefore, it was decided, at the committee, to use the term 'my' in the Spanish translation. When summarizing the content of the first committee meeting, 25 of the 48 items required discussion to reach consensus on the appropriate terms in Spanish. Item 41 presented the greatest difficulty: 'I experienced a meaningful connection with my nurses'. Although the term 'significant' was initially used to translate the term 'meaningful', the committee finally decided to use the term 'profound' instead. As a result of the work of the committee, the first version of the instrument in Spanish was obtained. This version was then back translated independently by two translators.

The two back translations were reviewed by the second expert committee including the author of the original scale. Four items (20, 25, 41, 47) needed clarification and underwent some few wording changes to attune them to the original meaning (see Table 3). For instance, item 20: 'My nurses encouraged me to **follow** my plan of care in order for me to leave the hospital' was initially translated using the Spanish term '**asumir**' [accept responsibility]. Nevertheless, the author indicated it would be better to use the meaning closer to 'follow' and therefore the Spanish term selected was 'seguir'. In relation to item 41, the meaning of the term 'meaningful connection' was discussed with the scale author and she emphasized the idea of 'mutuality' in the relationship. Finally, the Spanish term 'muy buena relación' [very good relationship] was used. The process concluded with the second version of the instrument in Spanish which was then piloted.

In relation to the pilot study, the participating patients (n-44) were on average 59 years of age: 66% male and 34% female, of whom 59% had university studies and 18% had professional training. The mean stay in the ward was 5.7 days. Three items (26, 36, 38) did not reach the required clarity percentage (= or >80%) for the patients, whereas, for the panel of experts, all items were clear and relevant.

In relation to item 26: 'Mis enfermeras me han hecho sentir que me conocían mejor que los medicos' [My nurses made me feel they knew me better than my doctors knew me], 10 patients did not find the item clear. Some of them indicated that it was not possible to know who knew them better, the physician or the nurse, and that they did not see difference between them.

Regarding item 36: 'Mis enfermeras me han preguntado sobre mis objetivos para la estancia en el hospital' [My nurses asked me my goals for my hospital stay], 20 patients did not find the item clear. 12 out of 20 indicated that the answer was obvious because their goal was to get better.

In regard to item 38: 'Mis enfermeras me han preguntado como el ingreso afectaba a mi familia' [My nurses asked how my being in the hospital affected my family], 10 patients indicated it was not clear. Two indicated it was obvious that admission affected their relatives. Another indicated that it did not make sense since he was the only one affected.

Finally, a committee formed by researchers and experts from the research group made the final decisions based on the results of the pilot study and decided to reformulate items 26 and 36 and keep item 38 as it was.

In relation to item 26, it was considered that specifying what type of knowledge the item referred to would increase the item clarity. Therefore, it was modified in the following way: 'Mis enfermeras me han hecho sentir que me conocían mejor cómo **persona** que los medicos' [My nurses made me feel that knew me better as a person that my doctors knew me].

Considering item 36, the committee ascertained that the concept 'goal' presented difficulties for patients as they considered it obvious that their aim was to be cured. It was decided to change the word 'goal' for 'expectations': 'Mis enfermeras me han preguntado que esperaba de este ingreso' [My nurses asked me what I expected from this admission].

Regarding item 38, the committee identified that rather than a lack of clarity, the problem was not recognizing the role of the professionals in the area of family care. Therefore, it was decided to keep the item as it was.

The three modified items were again piloted with five patients and all reached the clarity level. With the inclusion of the modifications after the pilot study, the third version of the instrument in Spanish was obtained.

TABLE 3 Items modified during Synthesis II.

Items	Original scale	1st Spanish version (after forward translation)	2nd Spanish version (after back translation)
20.	My nurses encouraged me to follow my plan of care in order for me to leave the hospital	Mis enfermeras me han animado a **asumir** mi plan de cuidados para que me puedan dar el alta	Mis enfermeras me han animado a ***seguir*** mi plan de cuidados para que me puedan dar el alta
25.	My nurses made me feel that they cared about me as a person	Mis enfermeras me han hecho sentir que se ***preocupaban*** *de mí como persona*	Mis enfermeras me han hecho sentir que se ***ocupaban*** *de mí como persona*
41.	I experienced a meaningful connection with my nurses	He ***experimentado una conexión profunda*** **con las** enfermeras	He ***tenido una relación muy buena con*** **mis** enfermeras
47.	My nurses cared about me	**Las** enfermeras ***se han preocupado por mí***	**Mis** *enfermeras* ***me apreciaban***

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Phase 2. The qualitative descriptive study

The average age of the seven patients participating in the study was 60; five were male and two were female. Five patients suffered from long-term chronic disease and two had surgery with short-term hospitalization. Four patients had primary education, one secondary education and two had third-level studies.

The findings obtained from the study analysis shed light on the patients' experience of being known by their nurses in a Spanish context.

In order to evaluate the conceptual equivalence between the original and target culture regarding the phenomenon of being known, the findings from the Spanish study are presented following the structure of the four attributes identified by Somerville (2009a). The similarities and differences within each one of the four attributes are presented. The Spanish study recognized aspects that were present in the original tool and some that were not reflected in the original. The latter were transformed by the researcher into items which were added to the Spanish version of the tool, thus obtaining the fourth version of the instrument.

Factor 1: Experienced a meaningful, personal connection with their nurses

This factor was defined by Somerville (2009b) as a shared consciousness and a mutual partnership between the patients and their nurses. Patients that have the impression of being known felt that their nurses were willing to share of themselves and that they did not only provide care but were interested in them. They felt the nurse's sense of engagement in the caring experience, that is, that they were truly present. This transformative experience changed the dynamic of the relationship from one of dependency to one of mutuality.

The Spanish study found that patients' perception of the genuine interest of the nurse led patients to be recognized personally and this contributed to a greater sense of personal well-being and trust in the professionals. They described the attitudes thanks to which they experienced genuine interest as availability, tact, affection, patience, closeness, and an optimistic approach. The following quotes provide examples of this idea:

> “There is a very important way of approaching the patient; they come to you without you needing to call them, they are aware of you as a person, of your problem ... Well, when a person arrives here, if he finds some nurses who treat him with affection, who seem to have known him forever, and who are going to do it with sensitivity: drawing blood, whatever nurses do, he will feel better, he will be more integrated immediately, and will be less fearful”
>
> (Patient 4).

> and then that they come to you like with joy. Yes, you're hospitalized, or whatever, but they mustn't suppose like ...Buf, do not worry because this I do not know what [in a shaking voice].This is part of life, it is what it is, and it does not matter
>
> (Patient 5)

The next quote supports the same idea, but from the perspective of the negative effects of the lack of those attitudes in the nurse–patient encounter.

> I have a bad experience, there was a nurse that I had to tell not to come to attend me anymore, because she came to give me heparin and if they give it to you here it is wonderful... she stuck it in and hurt you, she stuck in the needle and even the plastic of the needle. She was very bad, very bad with the sick. I don't know what her name is because I haven't bothered to know what it is, but she was very bad with the sick... You get one like that... It's hard. Here they are more aware, they come in, they look at you to see if you are asleep, if you are not asleep... more aware of you. ...I need something and boom, they bring it to you right away... and if you call them at night for the urine and they come, it's nice because they come in quietly, they don't make noise
>
> (Patient 2).

Most of these attitudes were already included in the original tool except accessibility, tact, affection and the optimistic view of the patient. As a consequence, the following items were added to the scale: ‘he percibido en mis enfermeras disposición para cuidarme en todo momento’ [I sense that my nurses are willing to take care of me at all times]; ‘Mis enfermeras han sido delicadas al cuidarme’ [My nurses have been thoughtful in caring for me]; ‘Mis enfermeras han sido cariñosas conmigo’ [My nurses have been affectionate to me]; and ‘La actitud de mis enfermeras me alentó durante la hospitalización’ [The attitude of my nurses encouraged me during my hospital stay].

Factor 2: Experienced being recognized as a unique human being

In the Somerville study (2009b) patients feel known when they were recognized by their nurses as unique. Through a purposeful interaction, these nurses gained insight into meaningful aspects that affect their patients' lives. As a consequence of grasping that uniqueness, they were able to provide care with respect for the patients' preferences and values.

Similar findings appeared in the Spanish study. Patients felt known when nurses knew them beyond their medical condition, that is, understanding, for instance, how the situation was affecting a patient's life, or being interested in their professional and social environment. The following quotes manifest this idea:

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> …that they know, then, where are you coming from, where are you from, where you live, how the disease has affected you, for how long you have that illness… is also important…
>
> (Patient 2).

> It is important that they knew what my job is, how is it restricting me… the disease in the everyday life…
>
> (Patient 5).

> Nurses should have some type of personal assessment of the patient, different from the clinical assessment
>
> (Patient 3).

The Spanish study also helped recognize that being known as a person was related to the nurses' ability to recognize and take charge of the veiled needs of the patient. The next quote provides an example:

> I have noticed an incredible sense of empathy and affection towards the patient, in the sense of taking care a little bit of what his needs are, not only the professional side, which I have already commented on before, but also those less quantifiable aspects that you feel much more when you are in this situation
>
> (Patient 3).

This idea of understanding and taking charge of patients' intangible needs, was not as such found in the tool items and was therefore added as a new item: 'Me he sentido comprendido por mis enfermeras' [I have felt understood by my nurses].

In addition, patients in the Spanish study also manifested the importance of nurses knowing what the situation of the patient's loved ones was and what their needs deriving from the patient's health situation were. One example of this idea is shown in the next quote:

> "They are not nannies either, but for example with [patient's husband name] do you need anything?' Or [patient's husband name] do you want…?' They behave well with him, that is, they take care of him". (Regarding the relationship of nurses with her husband)
>
> (Patient 7)

Based on these results, it was decided to add a new item so as to reflect that the nurses' care of the patient's family: 'Mis enfermeras estaban atentas a las necesidades de mi familia' [My nurses were attentive to my family's needs].

Factor 3: Feeling safe

In the Somerville study (2009b), the perception of feeling known was related to the patients' sense of confidence in the nurses' abilities and intentions to look after their well-being, to attend to their concerns and to assure their needs would be communicated to the other professionals looking after them.

Patients in the Spanish context also felt known when they perceived that the nurses showed interest in what was happening to them, looked after their interest, and took care of them. In addition, when patients felt known, they experienced a sense of trust and peace, as they felt they were in good hands. That sense of peace and dependency was not seen as negative but rather was positive.

> I give myself up [the meaning being, I put myself totally in the hands of the nurse], that is, I say: I am sick, I am here to get well, and so they should do what they have to. So, for me, the problem is over
>
> (Patient 7).

Patients also related to being known and feeling safe when they perceived a continuity in the nurses caring for them. When that continuity was not possible, they felt safe when their nurses communicated the patients' needs and clinical evolution to the other nurses looking after them:

> 'Yes, yes, do not worry, they have already given us the hand-over report, we have already asked, we already know' (referring to a nurse's words when the patient was asking about his care), that is, yes, that tranquility' …'Yes they have already told us, let's see how it is now', and they all knew. And 'the cough, how is it going? or …or is it getting better?', and another said: 'so you're still here!
>
> (Patient 5).

Therefore, an item was added to the original tool to reflect the continuity in the knowledge of the patient's clinical situation which was not explicitly reflected in the original instrument: 'Mis enfermeras conocian mi situación y evolución clínica cuando me cuidaban' [My nurses knew my situation and clinical evolution when they took care of me].

Factor 4: Feeling empowered by their nurses to participate in their own care

According to the findings of the Somerville's study (2009b), the experience of being known was related to patients' feelings of being recognized as well-informed partners in care. Being known helped patients to experience a sense of collaboration that encouraged them to be active participants in designing their care.

In the Spanish study, the feeling of being known encouraged patients to share their own experience and to seek dialogue with the professional. Patients valued nurses being available and willing to enter into dialogue:

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> They motivate you to talk, they help you talk to them or express anything that maybe you do not like, …so those things that I do not like or that I am not happy with…can be solved with no harm to anybody
>
> (Patient 6).

> So, being able to have that dialog and have that attention…so that they listen to you and being able to have that sharing in the whole process…that is important
>
> (Patient 5).

> The nurse needs …to talk to more with the patient"
>
> (Patient 3).

This idea of nurses appreciating the dialogue with patients as a value in itself was not found in the original scale and was included as a new item: 'Mis enfermeras mostraban interés en conversar conmigo' [My nurses showed an interest in talking to me].

Specifically, patients' felt known when nurses were interested on knowing the patients' own account of their health experience:

> In the end, the people who notice that improvement are us; the ones who are going through what is happening. Then, to be able to give your point of view, and that they listen to you…. They usually ask me: 'but how do you feel?' Apart from being better or worse or whatever, 'How do you feel?' Being able to inform, being able to participate in how I feel at this moment, this I think is important
>
> (Patient 5).

This idea was taken up and added to the tool through the following item: 'Me he sentido animado por mis enfermeras a opinar acerca de lo que es más conveniente para mi atención y recuperación' [I have been encouraged by my nurses to tell them my ideas about what is best for my care and recovery].

In the Spanish context, patients also indicated the relevance of the nurses' role in guiding and orienting the patient within the hospital environment which is unknown to them. It is important for patients to understand the resources that are available and to collaborate in their care. The following quote provides an example of this idea:

> I mean that since when someone is admitted into the hospital he is not very well, the truth is that when someone treats him a little kindly, helps him with things he doesn't know about, that is useful for him… "Well, and to manage within the problem, which is being sick"
>
> (Patient 4).

As a consequence, a new item was added: 'Mis enfermeras me han ayudado durante el ingreso a situarme en el entorno hospitalario' [My nurses have helped me to manage in the hospital environment during my stay in hospital].

Summarizing the findings in relation to the evaluation of conceptual equivalence, it was found that the same four attributes of the concept identified in the American context were present in the Spanish study. Nevertheless, the Spanish study revealed certain aspects related to each attribute that were not reflected in the American tool which were added to the tool in the format of 10 new items (see Table 4), thereby obtaining the fourth version of the adapted tool.

DISCUSSION

The present study aimed to throw light on how the examination of conceptual equivalence can be carried out within the process of the

TABLE 4 New items added to the PPSCE tool as a result of Phase 2: The qualitative descriptive study.

New items	Tool's factors
1. 'He percibido en mis enfermeras disposición para cuidarme en todo momento' [I sense that my nurses are willing to take care of me at all times] 2. 'Mis enfermeras han sido delicadas al cuidarme' [My nurses have been thoughtful in caring for me] 3. 'Mis enfermeras han sido cariñosas conmigo' [My nurses have been affectionate to me] 4. 'La actitud de mis enfermeras me alentó durante la hospitalización' [The attitude of my nurses encouraged me during my hospital stay]	Factor 1: Experienced a meaningful, personal connection with their nurses
5. 'Me he sentido comprendido por mis enfermeras' [I have felt understood by my nurses] 6. 'Mis enfermeras estaban atentas a las necesidades de mi familia' [My nurses were attentive to my family's needs]	Factor 2: Experienced being recognized as a unique human being
7. 'Mis enfermeras conocian mi situación y evolución clínica cuando me cuidaban' [My nurses knew my situation and clinical evolution when they took care of me]	Factor 3: Feeling safe
8. 'Mis enfermeras mostraban interés en conversar conmigo' [My nurses showed an interest in talking to me] 9. 'Me he sentido animado por mis enfermeras a opinar acerca de lo que es más conveniente para mi atención y recuperación' [I have been encouraged by my nurses to tell them my ideas about what is best for my care and recovery] 10. 'Mis enfermeras me han ayudado durante el ingreso a situarme en el entorno hospitalario' [My nurses have helped me to manage in the hospital environment during my stay in hospital]	Factor 4: Feeling empowered by their nurses to participate in their own care

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cross-cultural adaptation of tools and how it can contribute to tool development. For this purpose, the translation and adaptation of the PPFKN Scale to Spanish language and culture is presented.

The evaluation of the conceptual equivalence was carried out by adding two important elements within the conventional guidelines for cross-cultural adaptations. One was the involvement, within the adaptation process, of experts on the theoretical foundations of the scale from the target culture, and another, the exploration of the 'being known' phenomenon through in-depth interviews with a sample of patients from the target culture.

The presence of experts in the area of knowing the patient was essential to provide the translators with the conceptual context that made it possible to solve discrepancies and to make decisions regarding the most appropriate terms for more than half of the items from the scale. Although the presence of experts on the phenomenon from the target culture has not always being highlighted, this study supports the authors recommending this practice (Herdman et al., 1998; Prakash et al., 2019; Sidani et al., 2010).

In addition to the presence of the experts, the qualitative study made it possible to confirm the original four attributes of the concept and allowed for new insights within those attributes to appear. Those novel nuances of the 'perception of being known' were included in the translated version of the tool as new items. Those items collected aspects of the perception of being known relevant to the Spanish content and can be summarized as related to (i) the attention to the needs of loved ones; (ii) the perception of the genuine interest of the nurse to talk to and to listen to patient's experience, (iii) and the perception of being understood by the nurse.

For Spanish patients, the perception of feeling known is related to nurses' attention to the needs of their families. That connection between being known and the attention to the needs of the family carers is congruent with the family-centered lifestyle in Spanish culture. Families are usually extensively involved in the care of their relatives and suffer the impact of illness (Montoro-Gurich & Garcia-Vivar, 2019). This distress is a source of concern and added suffering for patients. Patients appreciate nurses being attentive to the needs of their relatives.

Another relevant finding from the research conducted was the recognition of how the genuine interest of the nurse, manifested by attitudes such as availability, tact, kindness, closeness and an optimistic approach towards the patient, favored the perception of being known. Benner (1989) had already spoken of the attitude of care as an essential aspect of nursing. This attitude, she explains, consists not just of doing or fulfilling tasks, but rather of not feeling indifferent to the other. It is an attitude of consideration, openness, interest and welcome (Benner, 1989). Saracíbar (2009) in her phenomenological study with patients and nurses on the meaning of the nurse–patient relationship, also found the same 'attitude of care' or 'nursing concern' to be an essential element within patients' experience of care and to be closely related to knowing the patient. In fact, according to this author, when the interest in the patient is authentic, it drives the nurse to find ways to develop roots in the patient's intimacy, that is, to grasp and comprehend the patient uniqueness.

The results of the study also identified that to 'be understood' by the nurse was associated with the perception of being known. To be understood, in the Spanish study, was related to the nurse's capacity for empathy, taking charge of the patient's situation and recognizing his/her less tangible needs. Recent literature highlights the understanding of patient's and/or families' unique experience, beyond the disease process, as the essence of nursing (Martín-Martín et al., 2022; Olano-Lizarraga et al., 2020, 2021, 2022). Precisely, according to these authors, this understanding of the unique health experience of patients and families is what allows nurses to help patients according to what they are like, that is, to provide personal care.

The above aspects identified within the translation and adaptation process of the tool seem to highlight aspects that are, according to the literature, considered part of the phenomenon of being known. The cultural context of Spain, characterized by strong family bonds and warm relationships, may have contributed to making more visible some aspects of the perception of being known that were less evident in other cultures. The findings from the present study suggest that cross-cultural adaptations can become enhancers of the theoretical understanding of measures as those studies can uncover aspects of the phenomenon that may become more discernible in cultures other than the original.

Therefore, in contrast with the advice of Herdman et al. (1998) stating that only the universal aspects of a measure should be included in the tool, that is, those that are relevant across cultures, the findings from the present study support the recommendations of Sidani et al. (2010) that those new aspects should be taken into consideration for the adapted scale as they contribute to clarifying aspects of the phenomenon that may remain hidden in other cultures.

Nevertheless, further studies to confirm the psychometric properties of the adapted scale need to be carried out to gain a more exact image of the value of the incorporated items and of the scale.

CONCLUSIONS

The present study has illustrated the relevance of conducting a comprehensive cross-cultural adaptation of tools which include not only linguistic and semantic aspects but also the analysis of the conceptual equivalence of the phenomenon. This analysis requires the involvement of experts in the concept together with bilingual translators, and the exploration of the phenomenon within the target culture. The evaluation of conceptual equivalence is especially significant when translating tools measuring complex, abstract, deep concepts such as that described in the present study, "patients' perceptions of being known", as they are more subject than others to cultural influences.

Moreover, the identification, acknowledgment and study of the conceptual differences in relation to a phenomenon between two cultures, becomes an opportunity for deeper analysis of the phenomenon of the tool, in order to understand its richness and depth, and to propose changes that may enhance the content validity of the tool.

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CLINICAL RESOURCES

Spanish nursing scientists research group, working under the "Model of the Interpersonal Relationship between the Nurse and the Person/Family Care for" developed by Saracíbar (2009): https://www.unav.edu/web/grupo-investigadores/innovacion-para-un-cuidado-centrado-en-la-persona.

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CONFLICT OF INTEREST STATEMENT

No conflicts of interest have been declared by the authors.

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