





**CROSS-CULTURAL ADAPTATION OF THE INTENSIVE CARE
PSYCHOLOGICAL ASSESSMENT TOOL IN COLOMBIA****ADAPTACIÓN TRANSCULTURAL DEL INSTRUMENTO INTENSIVE CARE
PSYCHOLOGICAL ASSESSMENT TOOL EN COLOMBIA****ADAPTAÇÃO TRANSCULTURAL DO INSTRUMENTO INTENSIVE CARE
PSYCHOLOGICAL ASSESSMENT TOOL NA COLÔMBIA**

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ABSTRACT

Hospitalization in the intensive care unit (ICU) can result in mental and physical disturbances post-hospitalization. In Colombia, there is little research exploring the early detection of psychological morbidity in the ICU. This study aimed to develop a version of the Intensive Care Psychology Assessment Tool (IPAT) in Spanish equivalent to the original instrument. Direct and reverse translations of the IPAT instrument were carried out with prior authorization from the authors and the participation of professional linguists. People with different sociodemographic profiles, hospitalized in the ICU, were interviewed to confirm the cultural adequacy of the Colombian version, as well as to compare it with the original version. It was found that items 1, 2, 3, 4, and 5 presented 100% comprehensibility, items 6, 7, 8, and 9 had 97.5% comprehensibility, and item 10 had 90% comprehensibility, requiring modifications. Life support measures such as mechanical ventilation, traumatic experiences, and memories of the hospital stay were detected as factors for the development of anxiety, depression, and post-traumatic stress disorder. It is hoped that this study will be a reference

point for new research based on cross-cultural adaptations related to psychological morbidity, in the nursing field in Latin America. The Colombian version of the IPAT instrument derived from this cross-cultural adaptation is equivalent to the English one. This study represents a starting point for new research that aims to develop a personalized and validated instrument in Spanish that can be used regularly by nursing staff in the near future.

Keywords: Psychological Tests; Morbidity; Critical Care; Psychological Stress; Traumatic Stress Disorders.

RESUMEN

La hospitalización de una persona en unidad de cuidados intensivos (UCI) puede generar alteraciones mentales y físicas post internación; en Colombia existen pocas investigaciones para la detección anticipada de morbilidad psicológica en UCI. Este estudio busca generar una versión al español equivalente al instrumento *Intensive Care Psychological Assessment Tool* (IPAT). Se realizó una traducción directa e inversa del instrumento, previa autorización de los autores se incluyó participación de profesionales lingüistas en las traducciones. Se aplicaron entrevistas a personas de diferentes perfiles sociodemográficos hospitalizadas en UCI, para verificar la adecuación cultural y comparación de la versión colombiana con la versión original. Se encontraron que los ítems 1, 2, 3, 4 y 5 presentaron comprensibilidad del 100%, los restantes ítems 6, 7, 8 y 9 comprensibilidad del 97,5% y el ítem 10 una comprensibilidad del 90% que requirió modificaciones. Las medidas de soporte vital como la ventilación mecánica, experiencias traumáticas y recuerdos de la hospitalización, han demostrado ser factores para desarrollar: Ansiedad depresión y trastorno de estrés postraumático, se espera que este estudio sea un punto de referencia para nuevas investigaciones basadas en adaptaciones transculturales de enfermería en Latinoamérica respecto a morbilidad psicológica. La versión colombiana del instrumento IPAT derivada por la adaptación transcultural es equivalente a la inglesa. El estudio sirve como inicio de nuevas investigaciones que busquen desarrollar un instrumento en español personalizado y verificado, y que pueda ser utilizado de forma habitual por el personal de enfermería en un futuro próximo.

Palabras claves: Pruebas Psicológicas; Morbilidad; Cuidados Críticos; Estrés Psicológico; Trastornos de Estrés Traumático.

RESUMO

A internação de uma pessoa na unidade de terapia intensiva (UTI) pode gerar alterações mentais e físicas pós-internação; na Colômbia há poucas pesquisas para a detecção precoce de morbidade psicológica na UTI. Este estudo busca gerar uma versão em espanhol equivalente ao instrumento *Intensive Care Psychology Assessment Tool* (IPAT). Foi realizada tradução direta e reversa do instrumento IPAT, com autorização prévia dos autores, foi incluída a participação de linguistas profissionais nas traduções. Serão aplicadas entrevistas com pessoas de diferentes perfis sociodemográficos internadas na UTI, para verificar a adequação cultural e comparação da versão colombiana com a versão original. Verificou-se que os itens 1, 2, 3, 4 e 5 apresentaram 100% de compreensibilidade, os demais itens 6, 7, 8 e 9 tiveram 97,5% de compreensibilidade e o item 10 teve 90% de compreensibilidade que necessitou de modificações. Medidas de suporte à vida, como ventilação mecânica, experiências traumáticas e memórias de hospitalização, demonstraram ser fatores no desenvolvimento de: ansiedade, depressão e transtorno de estresse pós-traumático, espera-se que este estudo seja um ponto de referência para novas pesquisas baseadas em estudos cruzados de adaptações culturais da enfermagem na América Latina em relação à morbidade psicológica. A versão colombiana do instrumento IPAT derivada da adaptação transcultural é equivalente à inglesa. O estudo serve como início de novas pesquisas que buscam desenvolver um instrumento

personalizado e verificado em espanhol, e que possa ser utilizado regularmente pela equipe de enfermagem em um futuro próximo.

Palavras-chave: Testes Psicológicos; Morbidade; Cuidados Intensivos; Estresse Psicológico; Transtornos de Estresse Traumático.

INTRODUCTION

The increase in chronic diseases, including cardiovascular, pulmonary, and kidney conditions, coupled with unhealthy habits in the population, has contributed to a rise in admissions to Intensive Care Units (ICUs), leading to overall deterioration and, in some cases, death.¹⁻² Intensive Care Units are renowned for providing care to individuals in critical health situations, and admission to these units constitutes a highly stressful experience due to its potentially life-threatening nature. Being in the ICU exposes individuals to continuous monitoring and invasive procedures that may be overwhelming and painful and results in feelings that could threaten the emotional stability of individuals, such as stress, anxiety, worry, restlessness, irritability, guilt, frustration, depression, and uncertainty.³

In this context, the literature establishes a link between ICU admissions and the presence of post-traumatic stress disorder. This disorder is defined as an intense emotional reaction to a traumatic event, leading to sensory and perceptual disturbances that disrupt well-being. Consequently, individuals who are discharged from intensive care units experience psychological burden.⁴⁻⁷

In response to the psychological burden following ICU discharge, various instruments have been implemented to provide insights into which patients may require more support than others. One noteworthy instrument is the Intensive Care Psychological Assessment Tool (IPAT), developed by Wade et al. in a study conducted in England. This research revealed that out of 154 individuals hospitalized in ICUs, 55% exhibited psychological morbidity, including 27.1% who experienced post-traumatic stress disorder, 44.4% anxiety, and 46.3% depression.⁸ These circumstances can impact a person's quality of life for up to two years post-discharge, resulting in both psychological and physiological repercussions for both the patient and the family.⁹

The same instrument was validated in Turkey, where it was found that the IPAT is a valid and reliable tool to identify psychological changes in people who have been admitted to the ICU. Regarding its ability to detect anxiety, this tool shows a sensitivity of 85% and specificity of 61%. Additionally, it has 74% sensitivity and 82% specificity to detect depression.¹⁰

Considering that there are few studies in Colombia that tackle the cross-cultural adaptation of instruments for early detection of future psychological morbidity among ICU patients and aiming to identify potential psychological effects for patients before ICU discharge, the need arose to create a Spanish equivalent version of the IPAT instrument. This questionnaire is a globally validated tool, widely used for detecting psychological morbidity in ICU patients.

METHODOLOGY

The design followed methodological procedures for cross-cultural and linguistic adaptations, encompassing six phases: Initial translation, synthesis of translations, resolution of discrepancies, back-translation from the target language to the source language, verification by an expert committee, pre-final version testing, and submission of documentation to the authors of the instrument.

A controlled study was conducted to determine the optimal strategy for data collection, organization, and analysis. The planning, development, certification, validation, and estimation of instruments are

topics addressed in methodological research.¹¹ As shown below, the methodology proposed by Beatón et al.¹² was used as a reference, systematically allowing control over the risk of bias associated with equivalence. The time employed in this process was one year.¹³

Stage I. Initial Translation

Two translations of the instrument were conducted, from the original language (English) into the target language (Spanish). These translations were performed by different translators, each of whom proved they were bilingual, and that Spanish was their native language. Additionally, each translator produced a written report.

As for the instrument, it consists of 10 Likert-type questions (A: No, B: Yes, a little, C: Not much), where A corresponds to 0 points, B to 1 point, and C to 2 points, totaling 20 points. A score equal to or higher than 7 indicates that the patient is at risk and requires psychological support. Completing the test takes no more than 10 minutes.

Stage II. Synthesis of the Translations and Resolution of Discrepancies

The presence and experience of previous translators and an observer was deemed necessary to meticulously compare the results, with the aim to determine the level of agreement between the translations. Subsequently, necessary modifications were made to ensure that the language used in the translated text was comprehensible to the target audience while maintaining the principles of semantic, conceptual, idiomatic, and experiential equivalence with respect to the source text.

Stage III. Back-Translation from the Target Language to the Source Language

Certified translators, who were unfamiliar with the original instrument, performed two back-translations from the unified Spanish version into English. Five authorized translators were part of the translator panel, two of whom were bilingual and responsible for the initial translation of the document from English to Spanish. The remaining three translators of British, American, and Colombian origin, were tasked with the back-translation.

Stage IV. Verification by Expert Committee

The committee included three healthcare professionals, an individual with language expertise (specifically, an English philologist), and two certified English translators. During the meeting, the initial translated version of the IPAT was finalized. Subsequently, the document was electronically delivered to the original authors to obtain the necessary authorization for its use in the study sample.

Stage V. Testing of the Pre-Final Version

The research was conducted in 2019 in the cities of Bogotá and Neiva, within the intensive care facilities of different hospitals.

During this phase, the penultimate version of the IPAT questionnaire was administered to the target population in a field test. In this case, the cohort consisted of 40 individuals hospitalized in the ICU who met the inclusion criteria.

The research involved intentionally selected individuals hospitalized in the ICU who met the following eligibility criteria: they were alert, conscious, oriented, and their native language was Spanish. Additionally, they had to be over 18 years old, admitted for more than 48 hours and having two or more hemodynamic supports. A total of 40 ICU-hospitalized individuals from the aforementioned cities were needed to test the pre-final translation of the cross-cultural adaptation of the instrument.¹⁴

Regarding data collection and analysis, the data were gathered through written questionnaires administered by the researchers in various intensive care units, after obtaining consent from the original authors of the English IPAT. Subsequently, the process continued to establish equivalence between the adapted and original questionnaires, adhering to the Guidelines for the Process of Cross-Cultural Adaptation of Self-Report Measures. This ensured idiomatic equivalence in Spanish. Additionally, conceptual equivalence was guaranteed through consensus among experts (healthcare professionals and linguistic experts) who adjusted terms to ensure the questions could be understood in Spanish. Finally, experiential equivalence allowed participants to understand the instrument through representations of daily life and culturally relevant experiences, including sociodemographic questions to characterize the population, analyzed using frequencies and percentages.¹²

After administering the IPAT instrument to the 40 individuals, interviews were conducted to analyze the comprehensibility of each question. Questions were coded as 1 if they were not understandable and 2 if they were understandable. This information was then tabulated, generating frequencies per question, which were presented in percentages. Subsequently, to analyze the comprehensibility of the questions and adjustments needed, an agreement was reached among the researchers: if the comprehensibility level was > 96%, no adjustments were made; if the value ranged between 90-95%, minor adjustments were required; and if the value was < or equal to 89%, fundamental adjustments were necessary.

Stage VI. Submission of Documents to the Authors of the Instrument

In the final stage of the adaptation, a report was delivered to the primary authors of the instrument and the committee responsible for reviewing the Spanish version.

Concerning the ethical considerations, authorization was obtained directly from the original authors to adapt the instrument. Moreover, the study was reviewed and approved by the bioethics committees of the institutions, under protocol numbers CEI-013-2019 and 045/18. Finally, ethical principles of the profession and international considerations were taken into account during the application, obtaining informed consent from the subjects of the research.

RESULTS

Regarding the diagnoses upon admission to the ICU, 37.5% of individuals were in the postoperative period of cardiovascular surgery, 17.5% had pulmonary disturbances, and 5% presented sepsis after general surgery and neurosurgery. Of the participants, 58% were aged 60 years or older, followed by 42% who were between the ages of 45 and 59. As for gender, 55% of the sample was female. Concerning socioeconomic status, 73% of the population belonged to strata 1 and 2, 25% to stratum 3, while strata 4 and 5 had negligible representation.

In terms of the participants' education level, 33% had completed high school, 25% had completed primary school, 18% had incomplete primary education, 13% had incomplete high school education, 3% had completed a technical degree, and only 8% had university education, which facilitated the understanding of the questionnaire.

On another note, the most prevalent support for individuals in the ICU was vasoactive at 45%, followed by ventilatory support at 41%, and, in third place, the use of renal replacement therapies at 9%. The average length of stay in the ICU for participants in this study was 10 days.

Concerning response methods, 62% of the group completed it independently, while 38% required some form of assistance due to physical deconditioning or visual impairment.

Regarding the clarity of the items, the first five questions achieved 100% comprehensibility, while questions 6 to 9 presented a comprehensibility rate of 97.5%. According to the research protocols, no

adjustments were required for these items. However, question number 10 obtained a comprehensibility rate of 90%, requiring an adjustment related to the extension of the question. The difficulty in understanding this question was influenced by the fact that it addressed experiences posterior to the ICU discharge, while the participants of the study were still hospitalized. The original wording of question 10 was: “¿Los recuerdos desagradables de la unidad de cuidado intensivo se repiten una y otra vez en su mente?” (Do unpleasant memories from the intensive care unit repeat themselves over and over in your mind?). Once adjusted, it became: “¿tiene repetitivamente recuerdos desagradables de la unidad de cuidado intensivo?” (Do you repetitively have unpleasant memories of the intensive care unit?). The final version of the IPAT was obtained after carrying out all the necessary adjustments (Appendix).

DISCUSSION

Fifty percent of the sample in this study had cardiovascular disturbances. This aligns with the findings of Quezada Vera et al., who emphasize that cardiovascular and respiratory conditions are the most common diagnoses found in the ICU.¹⁵ Similarly, Mas et al., found that 47.1% of the population showed cardiovascular disturbances.¹⁶ On the other hand, Castellero's research highlighted that 70% of individuals in the postoperative period of cardiovascular interventions expressed anxiety related to their health status, which is consistent with the present research.¹⁷

Regarding sepsis, the study by Velasteguí et al. reveals that survivors of a critical condition related to systemic infection often experience prolonged mental disturbances. These findings demonstrate that the quality of life of individuals going through an infection process while in the ICU is reduced. In the same study, the EuroQol-5D instrument was applied, which measures health-related quality of life and is deemed equivalent to the post-intensive care syndrome according to the authors.¹⁸ In contrast, IPAT is more specific to the mental sphere. However, it is essential to consider the diversity of clinical conditions, as these factors predispose them to developing psychological morbidity before and after hospital discharge.

The average age in the sample was 56 years, with 55% of individuals being female and 58% aged over 60 years. These results are in line with the research conducted by Romero et al., where the average age of the participants was 59 years. In that study, however, 67.5% of the sample consisted of men and 32.5% of women. Furthermore, the authors concluded that it is necessary to assess the presence of depression prior to admission in order to optimize the treatment of critically ill patients.¹⁹

In the present study, the inclusion of a broad range of age groups among adult participants in the pre-final version test increased the clarity of the elements and understanding of sociodemographic variables. Lastly, an extended stay in the ICU, coupled with life support measures such as mechanical ventilation, various traumatic experiences, and memories of hospitalization, have proven to be significant factors in developing depression, anxiety, and post-traumatic stress disorder. These conditions are characterized by a long-term persistence of symptoms, even 1 to 2 years after ICU discharge.²⁰⁻²² Additionally, it should be noted that there is a correlation between the mental distress experienced by caregivers and expenses, as well as issues around the effectiveness of institutional care.²³⁻²⁴

Considering all the factors mentioned above, it can be asserted that the comprehensibility of the items was ensured. This particular study has proven that the demographic group with the highest representation consisted of individuals over 60 years old, who also had prolonged stays, exceeding those described in the literature. This justifies the comprehensibility of the instrument.

One potential limitation for this study is the scarcity of publications in Colombia that adapt and validate the IPAT questionnaire. Therefore, it is expected that this study will serve as a reference

point for new research on transcultural adaptations in the field of Nursing in Latin America, for individuals with psychological morbidity.

In terms of implications for future research, it is necessary to conduct psychometric testing using the Spanish version of the IPAT on a statistically significant sample to assess internal consistency, as well as construct validity by comparing the instrument with others. Additionally, a factorial analysis employing different statistical tests should be performed.²⁵

The IPAT has been used to evaluate mental symptoms in ICU patients, translated and validated in various languages, including Persian, German, and Turkish. It can be employed in the acute phase and only considers psychological dimensions.²⁶⁻²⁸ It is worth mentioning that the recently validated Healthy Aging Brain-Care Monitor (HABC-M) scale displays good psychometric properties for detecting post-intensive care syndrome. However, the sensitivity and specificity of these tests in the Latin American context are currently unknown. Therefore, further studies are needed to determine which test may be more appropriate for assessing post-traumatic stress in the intensive care unit.²⁹

CONCLUSIONS

This transcultural adaptation of the IPAT was carried out for its implementation in the Colombian context, maintaining the conceptual, experiential, semantic, and idiomatic equivalence of the original instrument developed initially in a hospital in England.

This investigative work holds significant potential to strengthen the field of intensive care and serve as a starting point for future studies seeking to develop an instrument in Spanish or validate the IPAT in other Latin American contexts. Once developed, nursing staff can routinely administer this scale to detect signs of psychological morbidity in individuals who have been admitted to the ICU, making early intervention possible for this patient group.

Finally, the applicability and replicability of this study extend beyond the Colombian context, to other Spanish-speaking countries where there is currently no tool available for assessing post-traumatic stress.

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AUTHORSHIP:

MCJF, BVLE, PAJD: Conception, formal data analysis, manuscript writing, critical manuscript review, validation, and approval of the final version.

MCJF, BVLE: Data collection/obtaining results, research, methodology, and resources.

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APPENDIX:

Final Version of “Instrumento para la Evaluación Psicológica en Unidades de Cuidado Intensivo” (IPAT):

Fecha y hora: _____

Nombre del paciente: _____ Identificación del paciente: _____

Instrumento para la evaluación psicológica en unidades de cuidado intensivo

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Me gustaría hacerle algunas preguntas sobre su permanencia en la unidad de cuidados intensivos y sobre cómo usted se ha sentido. Estos sentimientos pueden ser una parte importante de su recuperación. Para responder, encierre con un círculo la respuesta más apropiada, o responda de la manera de que le sea posible (ejemplo: hablando o señalando).

	Durante su permanencia en la unidad de cuidado intensivo:	A	B	C
1	¿Ha sido difícil para usted comunicarse o que le entiendan?	No	Si, un poco	Si, bastante
2	¿Ha sentido dificultades para dormir?	No	Si, un poco	Si, bastante
3	¿Se ha estado sintiendo estresado o tenso?	No	Si, un poco	Si, bastante
4	¿Se ha estado sintiendo triste?	No	Si, un poco	Si, bastante
5	¿Se ha estado sintiendo con mucho miedo?	No	Si, un poco	Si, bastante
6	¿Ha estado sintiendo pérdida de la esperanza?	No	Si, un poco	Si, bastante
7	¿Se ha sentido desorientado (que no sepa dónde se encuentra)?	No	Si, un poco	Si, bastante
8	¿Ha tenido alucinaciones (ha visto o ha escuchado cosas que usted cree que no estaban allí)?	No	Si, un poco	Si, bastante
9	¿Ha sentido que las personas han tratado de lastimarlo(a) o de hacerle daño intencionalmente?	No	Si, un poco	Si, bastante
10	¿Tiene repetitivamente recuerdos desagradables de la unidad de cuidado intensivo?	No	Si, un poco	Si, bastante

¿Tiene algún comentario adicional con respecto a alguna de las preguntas?

PUNTAJE:

Cualquier respuesta en la columna A= 0 puntos

Cualquier respuesta en la columna B= 1 punto

Cualquier respuesta en la columna C= 2 puntos

Sume el puntaje de cada uno de los ítems para obtener un puntaje. El puntaje máximo es de 20.

Un puntaje > o igual a 7, indica un(a) paciente con riesgo.