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Breaking the Language Barrier:
The Spanish Translation of the Barriers to Access to Care Evaluation (BACE)

by
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Honors Thesis

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The Spanish Translation of the Barriers to Access to Care Evaluation (BACE)

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Author Note:

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Abstract

The Hispanic/Latino population in the United States has been identified as a high-risk group for mental health problems. Unfortunately, due to commonly reported factors such as lack of linguistically and culturally appropriate services, many fail to seek treatment. While growing research has focused on identifying and addressing the different barriers to accessing mental health care experienced by this community, there continues to be a lack of validated Spanish assessments to aid in the evaluation of these barriers. In hopes of overcoming this barrier, and working towards better quality of care for this growing population, this project translated the Barriers to Access to Care Evaluation (BACE) scale, a 30-item self-report instrument that measures barriers to accessing mental health care, and has a special focus on stigma related barriers. Through the completion of a translation, back-translation, and focus group ($n = 8$) stage, a Spanish-translated version of the BACE was developed. Future directions to validate the translated scale and continue evaluating the linguistic and cultural competency of the scale are discussed.

Breaking the Language Barrier:

Spanish Translation of the Barriers to Access to Care Evaluation (BACE) Scale

The United States (U.S.) is home to a growing racial/ethnic minority population which is expected to turn the nation into a “minority-majority” country by 2060, with Non-Hispanic Whites making up only 44% of the U.S. population (U.S. Census Bureau, 2015). This growth will largely be attributed to the Hispanic/Latino¹ population, which by 2060 will be the third fastest growing population in the U.S., falling behind the “Two or more races” and “Asian” population (U.S. Census Bureau, 2015, p.9). Unfortunately, although the Hispanic/Latino population continues to rapidly grow in the U.S., its members continue to face various challenges that ultimately affect their quality of life, notably in the field of health and mental health.

Mental Health of Hispanics/Latinos and Underutilization of Services

Although Hispanics/Latinos experience lower rates of most mental disorders compared to the general U.S. population, they have been identified as a high-risk group for anxiety, substance abuse, and especially major depression. This is particularly the case among U.S. born and long-term Hispanic/Latino residents who report higher rates of mental illness compared to recent Hispanic/Latino immigrants – a phenomenon that has been termed the “immigrant paradox.” This phenomenon suggests that the protective social and cultural factors in this population eventually wear off, as individuals become susceptible to increased pressure to assimilate/acculturate to the American culture (U.S. Department of Health and Human Services, 2001; Rios-Ellis et al., 2005; Aguilar-Gaxiola et al., 2012).

Unfortunately, despite high risk of suffering from a mental illness, many choose not to seek mental health care when experiencing symptoms. Compared to White Americans and other ethnic

¹ Definition of Hispanic or Latino Origin used in the 2010 Census: “Hispanic or Latino” refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

groups, Hispanics/Latinos have lower rates of mental health services utilization – this rate is especially lower among Hispanic/Latino immigrants. Moreover, if they seek treatment, they are twice as likely as Whites to do so in settings such as general health care or religious settings, compared to mental health specialty settings (U.S. Department of Health and Human Services, 2001; Kramer, Guarnaccia, Resendez, & Lu, 2009; Kouyoumdijan, Zamboanga, & Hansen, 2003).

Various factors play a role in this population's failure to access appropriate mental health care services. Among the commonly reported barriers are lack of knowledge of where to seek treatment, lack of proximity to treatment centers, transportation problems, and most commonly, fear of stigma and lack of available Spanish-speaking providers who are culturally and linguistically-trained to meet the needs of Hispanics/Latinos (U.S. Department of Health and Human Services, 2001; Rios-Ellis et al., 2005; Kouyoumdijan et al., 2003). Ironically, despite the growing research on the barriers that discourage Hispanics/Latinos from accessing mental health care, specifically language, there continues to be a lack of standardized instruments in Spanish that can be used to evaluate these barriers among the Hispanic/Latino community. This itself is a barrier preventing us from learning all that there is to know about the barriers to accessing mental health care experienced by this community, particularly from those with limited English proficiency. In order to continue furthering our knowledge about this issue and take appropriate action, a validated Spanish-instrument to evaluate these barriers is needed.

Hispanics/Latinos and Mental Health Stigma

While stigma seems to be the most pervasive problem preventing members of all racial and ethnic and minority groups from seeking behavioral health care for mental disorders, it is particularly a problem among members of the Hispanic/Latino community (Kouyoumdijan et al., 2003; Rios-Ellis et al., 2005; Aguilar-Gaxiola et al., 2012; Kramer et al., 2009; Rostain, Diaz, &

Pedraza, 2015). For Hispanics/Latinos, there is a culturally negative connotation associated with mental illness. In many Latino cultures, mental illness is associated with being *loco* (crazy), especially if the individual has to take medications to control their symptoms and behaviors. Having a member of the family suffering of mental illness usually reflects poorly on the family and can influence social relations with family and friends, and impact opportunities for education and employment (Aguilar-Gaxiola et al., 2012; Kramer et al., 2009; Rios-Ellis et al., 2005). Additionally, some Hispanics/Latinos tend to associate mental illness with loss of control, violence, incurability, and personal weakness (Kramer et al., 2009). As such, many Hispanic/Latinos will deny and conceal their mental illness out of concern of being judged or victimized by discrimination, thus explaining the low utilization of mental health services.

Lack of Linguistically and Culturally Appropriate Mental Health Services

Language is an important factor associated with the use of mental health services and the effectiveness of treatment. The lack of culturally and linguistically appropriate mental health services keeps many Hispanics/Latinos with mental illness from seeking services (Aguilar-Gaxiola et al., 2012; Rios-Ellis et al., 2005; Kramer et al., 2009; Karliner, Jacobs, Chen, & Mutha, 2007; Fernandez et al., 2004; Rostain et al., 2015; Kouyoumdijan et al., 2003). About one-fourth of Spanish-speaking people in the U.S. do not speak English well or at all. This translates into language barriers and often results in miscommunication and misinterpretations, with patients with poor English proficiency experiencing difficulty describing their symptoms or answering interview or assessment questions (which are often originally designed in English) to non-Spanish-speaking providers (Rostain et al., 2015; Kouyoumdijan et al., 2003). In addition, studies have shown that Hispanics/Latinos with limited English proficiency tend to be less satisfied with their care, compared with English-speaking Hispanics/Latinos or Whites in primary care settings, and

are often less willing to return for subsequent treatment (Kouyoumdijan et al., 2003; as cited in Fernandez et al., 2004).

Unfortunately, the number of Spanish-proficient providers, who can bridge both cultural and language barriers, remains insufficient to meet the needs of Hispanics/Latinos, especially monolingual immigrants (Rostain et al., 2015; Aguilar-Gaxiola et al., 2012). In 1999, a national survey revealed that out of 569 licensed psychologists with active clinical practices who were members of the American Psychological Association, only 1% of the randomly selected sample identified themselves as Latino (Rios-Ellis et al., 2005, p.6). While this number might have increased over the years, the amount of Spanish-speaking providers continues to remain limited. This is unfortunate because establishing therapeutic rapport with clients with limited English proficiency can be especially challenging if both patient and clinician are unable to appropriately communicate with each other (Kouyoumdijan et al., 2003).

Translators/professional interpreters are sometimes used to overcome language barriers and, for the most part, appear to raise the quality of clinical care for Hispanics/Latinos with limited English proficiency (Karlner et al., 2007; Rostain et al., 2015). However, problems still arise, as translations may sometimes be too literal – interpreters may sometimes simply translate what the clinician or patient is saying without considering context or meaning. This is troubling, as it can lead to clinicians who do not understand the patient’s reported symptoms, or patients who do not understand the clinician’s questions or explanations, thus possibly resulting in a misdiagnosis (Rostain et al., 2015).

Lack of Validated Spanish-translated Instruments

Despite recognition of the language barrier, there continues to be a lack of Spanish-translated versions of clinical assessment instruments that are both linguistically and culturally

appropriate to aid in the evaluation of important psychological constructs among Hispanics/Latinos. Unquestionably, translating an assessment from one language and culture to another is not an easy task. As such, when translating an assessment, the easiest approach is to achieve linguistic equivalence (same intended meaning) between the original and translated version (Matías-Carrelo et al., 2003). However, with a linguistically and culturally diverse population such as Hispanics/Latinos, linguistic equivalence is not enough. Instead, when translating assessments to evaluate such a population, it is important to take into account the cultural differences within the community, and thus develop an assessment that also achieves cultural equivalency. In order to do this, the assessment should achieve semantic equivalence (similar meanings of the items in each culture), content equivalence (the content of each item should be relevant to the population under study), technical equivalence (the original and translated version must yield comparable data when used in the different cultures), and construct equivalence (similar meaning of concepts from culture to culture) (Matías-Carrelo et al., 2003; Knight, Roosa, & Umaña-Taylor, 2009).

Not surprisingly, achieving such equivalence can be a difficult task, given the variance within the population. Due to this, focus groups and pilot studies composed of participants similar to the targeted group, as well as committees composed of bilingual and multinational experts, are highly recommended in order to evaluate the cultural equivalency of the assessment throughout the translation and adaptation process (Matías-Carrelo et al., 2003; Knight et al., 2009). While the process is time-consuming, and requires the expertise of different individuals, it is important to begin working towards increasing the availability of instruments in Spanish by translating already validated assessments, and taking the necessary steps to ensure the validity of the Spanish-translated version across this Hispanic/Latino population.

Need for a Spanish Language Barriers-Based Measure

As mentioned above, this lack of valid Spanish-language assessment tools extends to the research instruments necessary to further investigate barriers to accessing mental health care services. Despite knowledge about language as a barrier to accessing and receiving mental health care among Hispanics/Latinos, upon undertaking a literature research, I was unable to locate any validated measures of barriers to care translated into Spanish. As a result, in order to continue expanding on the information regarding the barriers to care faced by Hispanics/Latinos, while simultaneously removing the language barrier that is commonly reported among this population, I created a Spanish-language translation of a barriers-based measure known as the Barriers to Access to Care Evaluation (BACE). Availability of such a measure will allow practitioners and researchers to identify key barriers to care experienced by Spanish-speaking individuals suffering from mental illness, in a more standardized way. This, in turn, could help practitioners identify potential interventions to increase care seeking and improve treatment continuation within the Hispanic/Latino population. In addition, it could also be used to evaluate the change in barriers to care after interventions have been implemented. Ultimately, a linguistically and culturally appropriate measure, focusing on well-known obstacles to Hispanics/Latinos, is a step to better quality of care for this growing population.

The Barriers to Access to Care Evaluation (BACE) Scale

Barriers-based measures evaluate what prevents or delays individuals from seeking health care, which, in turn, may inform interventions to increase health care seeking and service use. The BACE is a 30-item self-report instrument that measures barriers to accessing mental health care, and has a special focus on stigma-related barriers – twelve of its items measure the extent to which stigma and discrimination are barriers to care ([Clement et al., 2012](#)). It was developed to address

the weaknesses of already existing measures that failed to provide a comprehensive list of barriers, referred to stigma as a barrier rather than inquiring about particular components of stigma, and evaluated presence of barriers in a dichotomous manner (yes/no), when barriers are experienced in a continuum (from a lesser to a greater extent) (Clement et al., 2012). As such, the BACE provides a comprehensive measure of barriers to access to professional care for mental ill health in a dimensional way (not at all, a little quite a lot, or a lot), encompasses care avoidance before and after contact with services, and can be completed by individuals with any type of mental health problem, regarding any type of professional care (Clement et al., 2012).

The BACE has demonstrated to have good psychometric properties. Its items were found to have acceptable test-retest reliability, and the scale was found to be significantly positively correlated with two other measures, the Stigma Scale for Receiving Psychological Help (SSRPH) and the Internalized Stigma of Mental Illness (ISMI), demonstrating convergent validity. The BACE has also demonstrated content validity, and was given an overall rating of 8 on the 10-point quality scale by respondents, indicating a positive respondent opinion of the measure (Clement et al., 2012). As a result, the BACE is being used in several studies around the world, and has motivated translations into other languages, to allow for a reliable measurement of barriers to accessing mental health care.

One translation of the BACE was created to evaluate the barriers to accessing mental health care in Brazil (Silva, Silva, Gadelha, Clement, Thornicroft, Mari, & Brietzke, 2013). Following specific guidelines, and considering the importance of accommodating the instrument to their current language, setting, and time, Silva et al., (2013) translated the BACE from its English original version to Brazilian Portuguese. The guidelines they followed resulted in the authors translating the scale's items and instructions, through the following process: 1) translation from

English to Brazilian Portuguese by two authors who are Brazilian Portuguese native speakers, one of whom is a psychiatrist; 2) evaluation, comparison and matching of the two preliminary versions by an expert committee; 3) back-translation to English by a sworn translator who is an English native speaker; 4) correction of the back-translated version by the authors of the original scale; 5) modifications and final adjustment of the Brazilian Portuguese version (Silva et al., 2013). In the end, the process resulted in the Brazilian version of the BACE, which at that time, was the only available instrument to evaluate barriers of care in Brazil.

This project will expand upon the guidelines followed by Silva et al. (2013) to translate the scale from English to Spanish by adding a focus group stage, in an attempt to develop a translated scale that achieves both linguistic and cultural equivalence. The guidelines followed for this translation project have been provided by the original authors of the BACE, and consisted of three different stages: 1) translation from English to Spanish by a translator whose first language is Spanish, and second language is English; 2) back-translation by a translator whose first language is English, and second language is Spanish; 3) focus group to “concept check” the scale items with a group of people similar to those who will be responding to the scale. In the end, this project attempts to translate the BACE scale from English to Spanish, in order to create a tool for evaluating the barriers to accessing mental health care among Hispanics/Latinos in the U.S, further our knowledge on the topic, and reduce the commonly reported language barrier this population faces.

Methods

Project Design

First, consent of the authors of the original scale, Professor Graham Thornicroft and Dr. Sara Evans-Lacko, was requested and obtained. Following this, translation of the Barriers to

Access to Care Evaluation (BACE) scale was undertaken, following the exact guidelines established by these authors in both their Manual for Researchers (2012) and accompanying article (Knudsen et al., 2000).

The translation process of the BACE scale consisted of 3 stages, as recommended by the scale authors: translation stage, back-translation stage, and focus group stage.

Translation stage

The BACE scale was translated from English to Spanish by two native Spanish speakers who have experience with Spanish translation. One of the translators also has a Ph.D. in Clinical Psychology and has had abundant experience conducting research with Spanish-speaking population. First, both translators independently translated the original scale into Spanish. When this step was completed, the translators met to compare the translated scales, discuss any discrepancies between the two, and create a single, preliminary, Spanish-translated version.

Back-translation stage

The preliminary, Spanish-translated version of the BACE was blind back-translated by an English native speaker, whose second language is Spanish. This back-translator also has great experience working with Spanish-speaking populations in a clinical research setting and conducting psychotherapy in Spanish. Once this step was completed, the back-translated version of the BACE was evaluated and compared to the original English version. Very few differences were found between the original version and the back-translated version of the scale. Nonetheless, the back-translated version of the scale was sent to the authors of the original version to evaluate. After evaluation, the authors certified that, despite the minor differences, the intended meaning of the original version of the scale remained the same in the back-translated version. As such, it was decided that any necessary changes to the preliminary, Spanish-translated version of the scale

would be made after the focus group stage.

Focus group stage

The main purpose of this final stage was to carry out what the authors call “concept checking;” that is, checking that the items of the Spanish-translated BACE scale are understandable with a group of people similar to those who will be responding to the scale (i.e. Spanish-speakers). This, in turn, will result in a scale that approaches both linguistic and cultural equivalence. In order to do this, a focus group was arranged.

A total of eight native Spanish speakers from the Richmond community (one Male and seven Females; 18-24 years) were recruited to participate in the focus group. Recruiting was done through word of mouth by the main researcher and a member of the general Richmond community with ties to the Hispanic/Latino community. Participants had to meet the following inclusion criteria to be part of the focus group: 1) identify as Hispanic/Latino; 2) be a Native Spanish speaker; 3) be fluent in speaking, writing, and reading Spanish. All participants spoke English as their second language. The focus group consisted of participants from Guatemala (2), Honduras (1), Peru (1), Puerto Rico (1), Ecuador (1), Paraguay (1), and Dominican Republic (1). Of these participants six of the eight participants were born outside of the United States

Although this project was not considered Humans Subjects Research by the University of Richmond Institutional Review Board (since participants would not be reporting information about themselves as a part of the focus group) informed consent was obtained from all participants prior to the start of the focus group. Consent forms were provided in both English and Spanish. At the beginning of the focus group, participants were instructed to individually read over the Spanish-translated scale and evaluate the comprehensibility of its items and instructions. Specifically, in an attempt to take into consideration the cultural differences among Spanish-speakers in the wording

of the scale, participants were asked to evaluate whether a person from their cultural/ethnic background would understand the scale. Any items that seemed unclear or confusing were brought up individually and discussed with the group. When necessary, the participants were shown the original English version of the specific items as a reference. Suggestions to change/modify the wording of the scale were presented by the participants. In order for the main researcher to refer back to these after the focus group, the discussion was audio recorded. Upon completion of the focus group (which lasted approximately two hours) each participant was compensated \$50 for their time.

Results

After completing all three stages of the translation process, a Spanish-translated version of the BACE scale was produced. Suggestions made during the focus group discussion were taken into consideration during the revision of the scale; however, not all were accepted and incorporated. For the most part, participants had no difficulty understanding the meaning of the items in the scale. Most of the suggestions to change/modify the items in the scale were specifically directed at terms that, due to literal translation from English to Spanish, were not clearly understood by the participants. As such, the necessary changes were made by replacing certain terms with words that facilitated understanding, but also maintained the intended meaning of the item. Examples of the terms that were changed are presented in Table 1. Participants also suggested changes such as a complete change of the grammatical person and tense of the items, in order to make the items sound more natural. However, this change was not made, in order to preserve the intended meaning of the original items in the scale.

Table 1
Examples of terms and expressions changed during the revision process

Version	Terms and expressions		
	Item (Instructions)	Item 10	Item 30
Original English version	Below you can see a list of things which can stop, delay or discourage...	Preferring to get alternative forms of care (e.g. traditional/religious healing or alternative/complementary therapies).	Having no one who could help me get professional care.
Translation to Spanish	A continuación, encontrará una lista de cosas que pueden parar, atrasar, o desalentar...	Preferir una forma de atención alternativa (ej. una cura tradicional o religiosa, terapias alternativas o complementarias)	Teniendo a nadie que me pueda ayudar a buscar atención profesional.
Back-translation	Below you will find a list of things that can stop, delay, or discourage	Prefer alternative services (ex., traditional or religious healing, alternative or complementary therapies).	Having no one who can help me find professional services.
Revised Spanish version	A continuación, encontrará una lista de ejemplos que pueden parar, atrasar o desmotivar...	Preferir otro tipo de cuidado (ej. una cura tradicional o religiosa, terapias alternativas o complementarias)	No tener a alguien quien me pueda ayudar a buscar atención profesional.

Note. Table format adopted from Silva et al., (2013).

Discussion

Following the specific guidelines provided by the authors of the original BACE, consisting of the completion of a translation, back-translation, and focus group stage, this project resulted in a Spanish-translated version of the BACE. The availability of a Spanish-translated version of the BACE scale will be beneficial in measuring the barriers Hispanics/Latinos are likely to face when accessing/obtaining mental health services in the United States, while simultaneously (at least in the research setting) tackling one of the biggest barriers this community faces in this country, particularly in healthcare: the language barrier.

The focus group participants in this project represented a variety of Spanish-speaking countries, in order to develop a Spanish-translated scale with improved linguistic and cultural

equivalence. Based on the similarity between the original English version and back-translation of the scale, the focus group participants' ability to understand the translated scale with little difficulty, and the need to only make a few changes to the items in the translated scale, it seems that this project reached its initial goal.

Particularly with the focus group participants' ability to understand the intended meaning of the different items and instructions, I have obtained some evidence for three of the four previously noted equivalences – semantic, content, and construct – needed to achieve cultural equivalence when translating instruments. However, in order to continue evaluating this, future directions for this project include a follow-up evaluation of the Spanish-translated version of the BACE and its comprehensibility, although this time with native Spanish-speakers with limited to no English proficiency. Unable to use the original English version of the scale to clarify the meaning of specific items, as the participants in the current focus group did, this step will better capture how understandable the items and instructions in the scale are to native Spanish speakers and will allow, if needed, for more precise changes/modifications. Furthermore, this group of participants should be more diverse, not just in terms of nationality/ethnic background, but also age and gender. Although I attempted to recruit focus group members from different countries and ethnic backgrounds, lack of diversity on other dimensions could limit the generalizability of this translation across different groups of Hispanics/Latinos.

Future directions also include evaluating the psychometric properties – reliability (internal consistency) and validity (convergent) – of the Spanish-translated scale with various Hispanics/Latinos, specifically those with a mental illness who have had and have not had contact with the mental health system. Evaluating the reliability of the scale will determine whether responses across the items are consistent. If so, this will demonstrate whether the Spanish version

of the BACE consistently measures barriers to accessing mental health care within the Hispanic/Latino population (Kline, 2009). The scale's convergent validity, specifically of the twelve items that focus on stigma related barriers, will be evaluated against a measure known as the Internalized Stigma of Mental Illness (ISMI) (Ritsher, Otilingam, & Graiales, 2003) which measures self-stigma among persons with psychiatric disorders and has been translated into Spanish (Bengochea et al., 2016). The ISMI and the BACE's stigma related items are presumed to measure a similar construct (Kline, 2009); therefore, demonstrating convergent validity will determine if the Spanish version of the BACE accurately measures the barriers to accessing mental health care within the Hispanic/Latino population, specifically those related to stigma.

Through the evaluation of the measure's psychometric properties, we will be able to evaluate its technical equivalence (the original and translated version must yield comparable data) and determine whether the translated scale measures these barriers similarly among individuals of different Hispanic/Latino background. Once technical equivalence and good psychometric properties have been demonstrated, the Spanish version of the BACE will be made available, free of charge, to interested researchers; this will eliminate the cost barriers associated with accessing many clinical assessment instruments.

In the end, this version of the Spanish-translated BACE is the first step towards a fully validated Spanish-language assessment that evaluates the barriers to accessing mental health care that Hispanics/Latinos might face – and, to my knowledge, the only such tool available. Availability of this scale allows future researchers the opportunity to systematically evaluate the key barriers to accessing mental health care, and continue furthering our knowledge on the topic. This may allow for the development of more targeted interventions to increase care seeking and decrease early termination of treatment among the Hispanic/Latino community, especially those

with limited English proficiency. More broadly, a project of this kind is a step towards increasing the availability of Spanish clinical assessments, particularly in a country like the U.S., where the Hispanic/Latino population continues to grow every day. Ultimately, in this community with high risk of suffering from a mental illness, addressing these different barriers is a step towards better quality of care.

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