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Starting from scratch: the Development of the Adolescent Quality of Life- Mental Health Scale (AQOL-MHS)

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Abstract

This article documents the initial development of a Spanish mental health quality of life (QOL) instrument based on the adolescents' own assessment of important domains to their QOL. Using a grounded theory approach, we targeted five mental health disorders: Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder (CD), Oppositional Defiant Disorder (ODD), Generalized Anxiety Disorder (GAD) and Major Depressive Disorder (MDD).

In-depth interviews (n=40) and three focus groups (n=20) were conducted and analyzed using qualitative methods to guide the development of items. A convenient sample of island Puerto Rican adolescents aged 12–18 was recruited from outpatient mental health clinics. Qualitative analysis revealed a total of 87 themes. They were distributed based on core QOL domains such as (1) Self (2) Peers, (3) Family (4) School, and (5) Environment. Items were written based on prevailing themes and using as closely as possible, words and phrases used by the adolescents to describe their views and perceptions of quality of life. The goal for the AQOL-MHS is to pinpoint specific areas of health related QOL for each psychiatric diagnostic group that will provide valuable information to assist both patients and providers set, define and evaluate adequate mental health treatment goals.

Keywords

Quality of Life; Mental Health; Adolescents; Qualitative analysis

Introduction

Health Related Quality of Life (HRQOL) has been firmly established as an important outcome in patient care and clinical research. Conventional measures of clinical outcomes and symptom reduction are only sensitive primarily to a narrow range of the problems faced by children with mental health disorders. These children usually exhibit problems at home, school and with friends, demanding a comprehensive model of care and a comprehensive model of clinical outcome measurement. Findings based on both children and adult populations have indicated that the extent of impairment in Health Related Quality of Life (HRQOL) associated with mental disorders is comparable with the impairment associated with physical illness (Chen, et al., 2006). Therefore, there is growing consensus that assessment of quality of life outcomes is crucial to provide a complete picture of children's physical and mental health status (Matza et al., 2004).

Quality of life can be viewed as a subjective, multidimensional concept which may include self-evaluation of all aspects of life (Chen et al., 2006; Patrick, et al., 2002). The World

Health Organization's (WHO) has defined QOL as an individual's "perceptions of their position in life in the context of culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns" (WHOQOL Group, 1994). QOL is related but not equivalent to other constructs used in adolescent research such as psychological wellbeing, self-esteem, adjustment, and happiness (Edwards, et al., 2002). In order to measure QOL in adolescents appropriately and comply with the WHO definition we should require that: 1) youth themselves define what they believe to be important concepts, 2) items be both culturally and developmentally appropriate and that 3) the items are self-reported. Also, this holistic view of QOL provides for a positive emphasis on health-enhancing aspects of life rather than a negative orientation. We believe that including an approach that provides positive aspects in the measurement of QOL will identify sources of resilience and strategies of coping which are rarely disclosed in deficit-oriented approaches (Edwards, et al., 2002). QOL should not be confused with functional status or disability, which refers to a child's ability to perform daily activities that are essential to meet his or her basic needs in the domains of interpersonal relations, school performance and self-fulfillment (Bird, et al., 2005). Clearly a youth's perception of his or her life *does not* necessarily correspond to the ability to perform a certain task or activity. In contrast, a QOL instrument should measure how the child feels about important aspects of his/her life such as school, family, peers, and the environment.

Nevertheless, few studies document HRQOL in either adolescent mental health or in Latino youth. An extensive review of instruments in adolescent HRQOL revealed that the majority of studies are specifically designed to measure the impact of a disease, such as asthma, diabetes, cancer and other chronic health conditions (Gorelick, et al., 2004; Yeh and Hung, 2003; Goodwin, et al., 1994; Ingersoll and Marrero, 1990). Remarkably, we were unable to find any HRQOL instruments *specifically* designed for evaluating mental health interventions. In order to address this gap, this study presents initial qualitative data necessary for the development of a quality of life instrument designed for Spanish speaking adolescents with mental health problems. Our initial testing of the instrument was conducted in a limited convenience sample of Spanish speaking Puerto Rican adolescents who met criteria for several psychiatric disorders. However, our ultimate goal is to continue the testing of this instrument in other Latino and English speaking populations in the US. The initial development of the instrument in Spanish is of importance given the 18 million Latino families with children in the US and the island of Puerto Rico. Of 4 million children born in the US every year, a growing number of households speak a language other than English with Spanish being the most prevalent minority language spoken by more than 35 million people (Guzmán, 2001; US Census, 2010). Assessment tools in Spanish will be urgently needed since, according to the National Survey of Children's Health of 2004, the primary language spoken at home was far more likely not to be English in Latino (60%) households compared with non-Latino white (1%) children's households (Flores and Tomany-Khorman, 2008).

Measures that are specifically designed for a condition have been shown to be necessary to detect small but important differences between treatment groups in evaluation of treatment effectiveness (Guyatt, et al., 1993). These measures are needed to capture the concerns of populations with specific health problems. Such specific measures follow an individual's changes in HRQOL over time and with treatment (within person); and for comparing HRQOL among different sub-groups of patients (between groups). They can be useful to provide differences between diagnostic categories or within the same diagnostic category, to examine differences in risk factors or treatment protocols.

The sparse research on mental health outcomes for Latinos can be partly attributed to the lack of appropriate outcome measures for Latino populations and even more so for Latino

children (Olson, et al., 2004; Bullinger, et al., 1998; Walker and Rosser, 1993). As previously stated, to our knowledge there is no QOL instrument designed specifically for adolescents with mental health problems. Because of this, researchers and clinicians have used generic QOL instruments to assess this outcome among adolescents with mental health problems. However, of the few generic HRQOL instruments for children and adolescents with Spanish translations, many do not have published reports that document the method of translation and adaptation, the psychometric properties or the research design that have been used for these translated instruments. Recent efforts to assess reliability and validity were found in European Spanish versions of the Vecu et Sante Percue de l'Adolescent (VSP-A) (Serra-Sutton, et al., 2006), the KIDSCREEN (Aymerich, et al., 2005) and the KINDL (Fernandez-Lopez, et al., 2004).

Mental health outcomes must be measured in the context in which they occur and must include family, school, community and cultural norms of mental illness, as well as the family's goals and expectations (Hohmann, 1996). When considering the components of a comprehensive quality of life assessment for adolescents, it is therefore important to recognize the varied cultural and contextual settings that influence the quality of life experience. As a result, we propose the development of a specific HRQOL instrument for adolescents with mental health problems, while also providing a culturally valid Spanish language outcome measure. This article presents the conceptual framework, methodological considerations and content-specific items in the initial development of a QOL instrument; the Adolescent Quality of Life-Mental Health Scale (AQOL-MHS). We aspire to ultimately design an outcome measure that will be able to accommodate both Spanish and English speaking adolescents with mental health problems, specifically the following five disorders: Attention-Deficit/Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), Major Depressive Disorder (MDD) and Generalized Anxiety Disorder (GAD).

Methods

Data Collection

In order to develop a pool of items that reflected what the youth themselves considered quality of life, we implemented a 2 steps process in which in-depth interviews and focus groups were conducted using a grounded theory approach. We recruited our participants by asking their help in developing a QOL instrument where their "expert" opinions would be paramount in achieving our goals of defining the important concepts and placing them within the cultural and developmental reality of these adolescents' lives. A convenience clinical sample of Latino adolescents was recruited with ages ranging from 12–18 years and diagnosed with one of five mental health disorders: Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder (CD), Oppositional Defiant Disorder (ODD), Generalized Anxiety Disorder (GAD) or Major Depressive Disorder (MDD). Exclusion criteria included; cognitive impairment, severe brain injury, pervasive development disorder or evident sensory impairment. The following data was collected.

- a. 40 semi-structured in-depth interviews with adolescents previously diagnosed by a mental health provider with ADHD (n=12), CD/ODD (n=11), or MDD/GAD (n=17) were conducted. In-depth interviews were taped, transcribed and analyzed to qualify and quantify themes using Atlas TI software. Major themes were pooled by quantifying their incidence.
- b. As step 2, three focus groups were conducted: ADHD (n=6), CD/ODD (n=8) and MDD/GAD (n=6) in order to refine the themes previously generated in step 1 and to analyze their importance. Focus groups were also taped, transcribed and analyzed for content using Atlas Ti software.

Participants were referred by clinicians that worked in several outpatient clinics in the San Juan metropolitan area. They were paid \$30 for participating in in-depth interviews and \$25 for focus groups. Adolescents recruited for the study were only allowed to participate once, either in the focus group or in the in-depth interviews. The recruitment and study protocol was approved by the IRB. In depth interviews were conducted by a clinical psychologist, and focus groups were conducted by a team of social and clinical psychologists. A total of 60 adolescents participated in the study (see Table 1).

Table 2 presents the demographic characteristics of adolescent participants and their parents for in-depth and focus group participants. All participants reported living in the San Juan metropolitan area. The majority of the adolescent participants were male. We used the Chi-Square test statistic for categorical variables to test differences between both groups. The age distribution and time in mental health service varied between in-depth and focus group participants. Focus group participants were slightly older and reported receiving mental health services for less number of years. Significant differences between groups were also observed in parental economic status, marital status and age. No differences were observed for gender or education. The majority of parents that participated in the in-depth interviews were younger and reported being single. There was also a different distribution of economic status; the majority of focus group participants reported living from “check to check” in other words, just making ends meet; the midpoint on our scale. In-depth group participants were equally distributed at both extremes on our scale (live well/comfortably and almost poor/poor).

Procedure

A semi-structured in-depth interview that lasted approximately an hour was developed by a group of clinicians taking into account major concepts of QOL theory, developmental stages and clinical diagnosis. This interview consisted of two major parts. During the first part participants were assessed through open ended questions about their understanding and perception of the meaning of *quality of life*. They were asked to generally discuss their feelings toward self and family, general activities, support system, family dynamics, school, environment, goals and expectations. The second part of the in-depth interview was developed to evoke discussion of QOL from the standpoint of having a diagnosis. The participant was asked about his/her perception of having a diagnosis, self image and feelings in relation to the diagnosis, perception of his/her ability to enjoy good quality of life in relation to the diagnosis, individuals view of diagnosis as impairing or liberating, individuals image in relation to others and to general achievement, social resources and support, goals for the future, and specific worries related to the diagnosis.

Following Strauss and Corbin's (1990) data coding strategies included: open coding, axial coding and selective coding. We tried to be as theoretically sensitive as possible by being careful to perceive variables and relationships in our data within a social cultural perspective. We first assigned codes to the text based on words or phrases that captured meaning in the data (open coding). Once these open codes were created, we compared them with each other to create relevant categories (axial coding). We used the frequently occurring axial codes to create core categories (selective coding). Adolescent's interviews were used as the primary basis for open and axial coding. Core categories mentioned by adolescents in the in-depth interviews were then used as part of the discussion for each of the focus groups. Themes were also generated from the focus groups discussions but mostly served to affirm that no key themes were missing or of the importance of the themes for each of the diagnostic groups.

Coding, analysis, and theme creation for both in-depth interviews and focus groups were first developed independently by each researcher working with the transcribed interviews.

Our team of researchers included two clinical psychologists, one social experimental psychologist, one school psychologist and two research assistants with a bachelor's degree in psychology. If any disagreements arose during coding, the issue was discussed and then put to a vote so that the majority opinion would prevail. Using the pool of core themes generated from both in-depth interviews and focus groups for each diagnostic group (ADHD, CD/ODD and MDD/GAD), the groups of clinical and academic experts were then required to write items, based as closely as possible, on the views and using the words/phrases used by the adolescent themselves. This generated an item bank based on all the available themes.

Results

In-Depth Interviews

Qualitative analysis of the in-depth interviews revealed 36 distinct themes for ADHD, 32 themes for ODD/CD and an additional 19 themes for MDD/GAD. Themes were pooled in order to quantify their incidence. The 10 most frequent themes specific for adolescents diagnosed with ADHD were (number in parenthesis represents the frequency of the mentioned theme): Activity Sports (20), Conduct (18), Study (17), Inattentive Symptoms (15), Socialization (12), Respect (11), Looking toward future/goals (11), Friends (11), Activity Electronics (10) and ADHD symptoms (10). For those adolescents diagnosed with CD/ODD the 10 most frequent themes were: Study (34), Conduct (33), Activity Sports (32), Family (26), Socialization (24), Anger/Aggression (24), Obedience/Discipline (19), Family Conflict (18), Defiance Control (18), and Legal Problems Violations (13). The 10 most frequent themes for adolescents diagnosed with MDD or GAD were: Study (46), Support (41), Socialization (38), Looking towards the future/ Goals (29), Family (24)/Family Bonding (15)/Family Conflict (15), Struggle to Succeed/Survive (21), Activity/Arts (21), Emotional Health (20), Sad/Loneliness (20) and Coping Skills (19).

Focus Groups

As part of focus group activities, the adolescents were asked to rate in order of importance those themes that had been previously identified in the in-depth interviews as being highly prevalent for each diagnostic group. By using this ranking system we are able to present the major themes identified by the adolescent's themselves as being the most important to their QOL (Table 3). This analysis was conducted independently for each diagnostic group.

Integrating results from both in-depth interviews and focus groups

We observed that in general, the prevalent themes in each group were highly related to the symptoms or consequences of the diagnostic category to which the youth belonged. Despite the fact that raters were of different disciplinary backgrounds, these themes were universal enough to allow for easily achieved agreement according to the salience and prevalence. ADHD's adolescents discussed themes related to inattentive behavior and lack of friends. Unique to CD/ODD adolescents was the persistent discussion of the absence of a parental figure and the importance of family activities/bonding in their lives. The MDD/GAD group revealed themes denoting awareness of feelings towards self and others, as well as a high prevalence of themes related to coping skills and activities that factored in their emotional health and their ability to succeed/survive in their surroundings. Similarities in themes across groups revealed that of most importance for QOL in both ADHD and CD/ODD groups was the ability to practice sports activities. Communication, coping skills, and looking towards future goals seemed to be the most prevalent between MDD/GAD group and CD/ODD group. Socialization (or being able to socialize) seemed to be the most prevalent theme in all three diagnostic groups. We generated a total of 87 themes from analyses of in-depth interviews and focus groups. They were distributed based on core QOL

domains such as (1) Self (2) Peers, (3) Family (4) School, and (5) Environment. Tables 4 shows the progression from theme to verbatim dialog by the adolescent, followed by an example of an item developed from this theme. The table is divided by diagnostic group.

Research staff and an additional two experts in psychological assessment and psychometrics evaluated each of the items based on all the available themes and chose what they considered to be the best items by working individually. Following standards from the Seattle Quality of Life Group (Patrick, D. L.), the criteria used to retain the best items was as follows: (1) item evaluates a feeling (perception/sensation); (2) item represents an area of importance to adolescents with the MH diagnosis (specifically the 5 diagnoses samples); (3) item is in the language of the people with the condition, and the item is translatable conceptually; (4) item is likely to change with successful treatment of the condition; (5) item is likely to discriminate with severity of condition; (6) item discriminates between known population groups; (7) item represents a content area frequently mentioned by participants; and (8) item is relevant to everyone with the condition. Based on our experience with translation and adaptation of instruments, we also added an extra criterion that the item has semantic equivalence with other languages.

The remaining item bank was modified to include the experts' recommendations and then scrutinized in order to verify that (a) the most frequent themes per diagnosis were represented, (b) an equal distribution of items per diagnostic category was achieved, (c) an equal distribution of internalizing and externalizing items remained, (d) a proportionate distribution of QOL core domains (self, peers, family, school and environment) was achieved and (e) the items reflected feelings and perceptions and not simply psychological symptoms or physical limitations. Afterwards the item bank was given to an additional expert to evaluate and further nominate the best items. Once all the experts' recommendations were discussed and analyzed by the research team, the final number of items was reduced to 60.

Discussion

The qualitative analyses detailed in this article yielded a new instrument that focuses on the QOL of adolescents with mental health problems, the AQOL-MHS. We set out to fill a current gap in the evaluation of HRQOL and currently, to our knowledge, there are no other instruments specifically designed to assess Quality of Life in adolescents with ADHD, CD/ODD, MDD, and GAD disorders from their own perspective. We believe that this instrument will provide the clinician with additional insight into the different aspects of quality of life that are important to adolescents with mental health problems. An important contribution of this instrument is that it does not focus on functioning as do many other available QOL instruments; therefore, it provides valuable information into areas that are not usually tapped by currently available measures. It is also *not* a parent version that has been simplified in readability level to achieve a child or adolescent versions of the instrument. This instrument was developed by using the way adolescents' express themselves in formulating items that considered their unique perspective and feelings toward that which they considered important to their quality of life with special emphasis on the impact of having a mental health disorder. In combination with other assessment measures, we believe this instrument will add crucial value in providing researchers and clinicians a complete assessment of children's mental health.

As expected, most adolescents interviewed agreed that not having a mental health condition would indeed improve their quality of life. They reported that having a diagnosis has made life more challenging for them regarding achieving their goals, socialization, and dealing with either school or family issues. They also worried about the specific consequences this

would have on their future and some saw themselves “as lost” or “prone to be ridiculed.” Others discussed the fear of having further complications because of their diagnosis, which would then result in an even worse quality of life in the future. Generally speaking, adolescents acknowledged feeling fear, shock, discomfort or hopelessness after having been told they had a mental health diagnosis. These feelings were sometimes ambivalent, on one hand it was difficult to accept the news of their condition, and on the other by accepting they had a diagnosis they would also be more willing to receive help. There were also others that expressed relief and hope after their mental health practitioner discussed their diagnosis with them. Relief came when they were able to discuss and pinpoint their feelings and receive help and guidance to identify emotions and control specific behaviors. They also articulated hope at the possibility of being cured in the future or accomplishing their desired goals in spite of their diagnosis. Therefore in the development of the items, we took into account all aspects of having a mental health disorder that impacted QOL, both positive and negative.

There are many possible applications for a measure that assesses quality of life in adolescents in the context of mental health services. Quality of life measures developed for children and adolescents are useful tools for assessing the efficacy of mental health treatment in children. Culturally sensitive instruments are greatly needed for Latino populations to evaluate whether evidenced based treatments developed for non-Latino white populations are as effective with Latinos. The development of evidence based treatments adapted to minority populations is becoming increasingly relevant to both private and public mental health sectors. Therefore an instrument developed to aid in the evidence based assessment of clinical interventions is currently a vital assessment need. The added benefit of being able to pinpoint specific areas of health related QOL for each psychiatric diagnostic group will also be of great importance in the development of an instrument designed to assist both providers and parents set, define and evaluate adequate treatment goals.

There are several limitations to this study. An important limitation of the present report is the limited generalizability of our findings. We collected judgments from a non-probabilistic convenience sample of Spanish speaking island Puerto Rican adolescents recruited primarily from mental health outpatient clinics serving primarily low income and middle income populations. As such, it would be important to conduct studies using larger probabilistic samples, with a more diverse population of Latinos. There are numerous other Latino subgroups that comprise the Latino population in the U.S. Therefore it cannot be assumed that this instrument will have cross-cultural equivalence for other Latino subgroups or mainland Puerto Ricans. However our multi-national bilingual team has over 30 years experience in the translation, adaptation and testing of multiple diagnostic and epidemiological instruments, with a common goal of maximizing the likelihood that the Spanish used in the instruments be applicable to diverse Spanish-speaking populations. We have used this Spanish language approved by multi-national consensus in the development of the items of the AQOL-MHS and because of this, we believe this version is likely to be a useful starting point for adjusting the AQOL-MHS to other Latino groups. Any additional version of the instrument would benefit from a closer look at how adolescent’s local regionalisms in specific Latino groups are manifested in the way they express their quality of life concerns.

A new Spanish QOL instrument was developed for adolescents with mental health problems by using established qualitative methodology and by keeping as faithfully as possible, to the adolescents’ own words/expressions, while voicing their concerns. We hope that with further inclusion and testing of other Latino and English speaking groups, the resulting instrument will be useful and feasible to clinicians and meaningful from the perspective of the adolescent consumer to ascertain and accomplish treatment goals. The next step in this process of instrument creation will entail the testing of the psychometric properties of the

AQOL-MHS. This includes: discriminant and known-groups validity, test-retest reliability, scale structure, responsiveness to change and respondent burden.

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Table 1

Total Number of Participants by Diagnostic Group and Gender

Participants by Diagnostic Category	In-Depth Interviews		Focus Group		Total N by Diagnosis
ADHD	Male=8	Female=4	Male=5	Female=1	18
CD/ODD	Male=9	Female=2	Male=7	Female=1	19
MDD/GAD	Male=10	Female=7	Male=0	Female=6	23
Total	n=40		n=20		N=60

Table 2

Demographic Characteristics of In-depth and Focus Group participants and their Parents

Adolescents Characteristics	In-depth	Focus Groups
	%	%
Gender		
Male	65.9	55.0
Female	34.1	45.0
Age *		
11–14 years old	46.3	5.0
15–16 years old	31.7	55.0
17–18 years old	22.0	40.0
Time in mental health treatment *		
< 1 year	18.4	41.2
1–4 years	42.1	47.1
5 or > years	39.5	11.8

Parents characteristics		
Gender		
Male	20.0	10.0
Female	80.0	90.0
Education		
High School	57.5	50.0
More than high school	42.5	50.0
Economic status *		
Live well/ comfortably	39.5	30.0
Live from check to check	21.1	50.0
Almost poor/poor	39.5	20.0
Marital Status *		
Single	60.0	30.0
Married/Living as a couple	22.5	30.0
Separated/Divorced/Widowed	17.5	40.0
Age *		
Up to 35 years	25.0	11.8
36–45 years	55.0	52.9
46 and above	20.0	35.3

Note

* indicates a significant difference $p < .05$

Table 3**Top Ten Themes by Diagnostic Group**

CD-ODD	ADHD	MDD-GAD
1. To get along with my family.	1. To feel I can accomplish my goals.	1. To feel good about myself and my surroundings
2. To believe in God/have faith.	2. To have a good attitude towards others.	2. To feel I can control my emotions.
3. To fight/struggle to have a future.	3. To get good grades.	3. To feel I have to do well at school/get good grades.
4. To behave well.	4. To respect other /not to offend others.	4. To participate in activities with my family.
5. To stay away from problems.	5. To pay attention/concentrate at school.	5. To know my parents support and understand me.
6. To have a good attitude.	6. To do things/participate in activities with others.	6. To know how to manage my problems and difficult situations.
7. To be thankful.	7. To behave well with others/not be rude.	7. To be able to confide in someone and not to close myself up.
8. To respect others.	8. Avoid looking for or getting in trouble.	8. To push forward in spite of having problems and how I feel.
9. To eat healthy.	9. To know I am healthy/to have good physical health.	9. Not to feel sad and distant from others.
10. To be happy.	10. Don't do things in a rush/to do them slowly	10. To feel up-beat/not feel tired all of the time.

Table 4

Item History (Theme-Verbatim-Item) by Diagnostic Group

ADHD			
Theme	Verbatim	Item in Spanish	Item in English
Looking Towards the Future/Goals	"My studies, to be a good professional and to have a family when I grow up." ("Mis estudios, ser una buena profesional y tener una familia cuando sea grande".)	El tener una meta clara me podría ayudar a prepararme para el futuro.	Having a clear goal might help me prepare for the future.
Conduct	"Sometimes I throw things, I misbehave, I'm not nice to my mother. Yesterday I was rude to my teacher." ("A veces tiro las cosas, me comporto mal, le hago malas crianzas a mi mamá. Inclusive ayer le contesté a la maestra para atrás".) "To be out of control and not know what you are doing." ("Estar al garete y no saber lo que estás haciendo".)	Actúo fuera de control, algarete.	I act out of control, wild.
Study	"He didn't get along with me, do you understand? I felt rejected. No one liked me; none of my teachers liked me..." ("No se llevaba conmigo, entiendes? Yo me sentía rechazado. ...No me quería nadie, ningún maestro me quería...")	Es importante para mí que mis maestros me apoyen.	Having the support of my teachers is important to me.
Respect	"I can be disrespectful to everyone, not get along, always getting into fights, being disrespectful to everyone, and not go to school things like that..." ("Bueno puede estar faltándole el respeto a todo el mundo, no tener compañerismo, siempre estar peleando, faltándole el respeto a todo el mundo, no ir a la escuela cosas así...") "When someone talks to me I don't care, I am not interested and whatever..." ("Cuando me hablen, no me importa, no me interesa y whatever...")	Hago las cosas sin pedir permiso.	I do things without asking for permission.
CD/ODD			
Family Bonding/Support	"Whenever I have a problem, they (parents) give me a hand and help me succeed." ("Cada vez que yo tengo problemas, ellos (padres) me ayudan y me sacan adelante".)	Mi familia me apoya en las cosas que hago	My family supports me in the things I do
Spirituality	"When I'm depressed, I pray." ("Cuando me da depresión me pongo a orar".)	Mi fe y mi espiritualidad son lo que me sostienen en momentos difíciles.	My faith and spirituality are my source of strength in difficult times.
Looking towards the future/goals	"To feel happy, to have reached the goals that I set for myself and to know that I was able to raise my grades and do better." ("Sentirme feliz, haber logrado las metas que yo me propuse y saber que pude subir las notas y salir adelante".)Based on the goals I have in my mind, I feel that I will achieve them. ("... de mis metas que yo tengo en la mente yo siento que yo las voy a cumplir".)	Confío en que puedo lograr lo que me proponga.	I am confident I will achieve whatever I propose for myself.
Obedience/Discipline	"...and you want to do whatever you want, the way you want, you are a person that likes to fight and I don't like to be like that. Sometimes I can be relaxing in a quiet place but sometimes you get anxious and you want to fight and you want to hit someone, you want to do whatever you want and you want to run somewhere and tell your mom and don't care what you say..." ("...y tú quieres hacer lo que te dé la gana a tu pantalón, tu eres una persona que eres peleona y a mí no me gusta ser así. A veces pues tu puedes estar tranquilo en un sitio chilin pero a veces de	Cuando las cosas no me salen como yo quiero, hago lo que me da la gana.	When things don't turn out my way, I do whatever I want.

	momento te da la ansiedad y quieres pelear y quieres darle a alguien, quieres hacer lo que te da la gana, quieres salir corriendo y decirle a tu mamá a mi no me importa lo que tú digas...")		
MDD/GAD			
Emotional Health	"Because adolescents are suppose to have fun and hang out with friends at parties but I kind of never feel like doing anything and I wish I could enjoy things like before." ("Porque los adolescentes son para disfrutar y estar saliendo con los amigos y yendo para las fiestas pero como que yo nunca tengo ganas de hacer nada y quisiera disfrutar como antes".)	Cuando me siento triste, no me interesa estar con otras personas.	When I am sad, I feel no interest in spending time with others.
Emotional Regulation	"What worries me the most is that at times I get aggressive, and I don't think about the consequences, then later I realize." ("Lo más que me preocupa es que a veces me torno medio agresivo y no miro las consecuencias, después es que caigo en sí".)	Siento que puedo controlar mis emociones.	I feel able to control my emotions.
Study	"Sometimes I missed school to stay in bed or because I didn't want to go. My grandmother used to take me and I would just leave." ("A veces faltaba por quedarme para dormir o porque no quería ir. Mi abuela me llevaba y yo me iba (de la escuela)".) "What I really want is to drop out of school." ("Salirme de la escuela es lo que yo quiero".)	Estar en la escuela no me sirve de nada.	Going to school is worthless.
Family/Family Bonding/Family Conflict	"Most of the time we are ok, but there are always conflicts (...). They are over there; like worried about their stuff, and I am worried about my stuff. Neither of us has time to mix knowledge." ("La mayoría del tiempo bien pero siempre hay conflictos (...). Ellos están allá; como que preocupados con lo de ellos y yo preocupado por lo mío. Ninguno de los dos tenemos tiempo para estar mezclando conocimiento".) "Oh my God, How well do I get along with my parents? With my Mom I keep fighting every day... With my Dad, sometimes he scolds me and I say ha! And I go to my room and I lock myself in. I curse at myself." ("Ay Dios mío. ¿Cómo me llevo con mis padres? Con mi madre me paso peleando todos los días... Con mi papá algunas veces me regaña y yo le digo ah y me voy pa'l cuarto y me encierro. Yo misma a maldecirme".)	Tengo problemas con mi familia porque no son justos conmigo.	I don't get along with my family because they are unfair to me.