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Authors

Guo, Yuqing
Rousseau, Julie
Hsu, Anna S
[et al.](#)

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**Emotional and Behavioral Health Needs in Elementary School Students
in an Underserved Hispanic Community**

Yuqing Guo, Ph.D., RN (Corresponding Author)
Assistant Professor
Sue & Bill Gross School of Nursing, University of California, Irvine
299D, Berk Hall
Irvine, CA, 92697-3959
Phone: 949-824-9057
Fax: 949-824-0470
Email: gyuqing@uci.edu

Julie Rousseau, Ph.D., CNM, RN
Associate Clinical Professor
Sue & Bill Gross School of Nursing, University of California, Irvine
Irvine, CA, 92697-3959
Email: jroussea@uci.edu

Anna S. Hsu, Ph.D.
Department of Psychology and Social Behavior
University of California, Irvine
ashsu@uci.edu

Priscilla Kehoe, Ph.D., RN
Director of Research
Sue & Bill Gross School of Nursing, University of California, Irvine
Irvine, CA 92697-3959
Email: pkehoe@uci.edu

Monique Daviss, BA
Executive Director
1010 N. Broadway Street, Santa Ana, CA 92701
Phone: 714-543-0023
Email: mdaviss@elsolacademy.org

Sara Flores, MA
Director of Community Life & Early Childhood Education
1010 N. Broadway Street, Santa Ana, CA 92701
Phone: 714-543-0023
Email: sflores@elsolacademy.org

Patricia Renno, Ph.D.
Postdoctoral Scholar
Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles
Semel Institute for Neuroscience & Human Behavior, Rm. 68-229
760 Westwood Plaza
Los Angeles, CA 90095-1759
Email: prenno@ucla.edu

Kathleen Saunders, MSN, RN, CNS
Associate Clinical Professor
Sue & Bill Gross School of Nursing, University of California, Irvine
209, Berk Hall
Irvine, CA, 92697-3959
Phone: 949-824-9694
Email: ksaunder@uci.edu

Susanne Phillips, Clinical Professor, DNP, APRN, FNP-BC, FAANP
Sue & Bill Gross School of Nursing, University of California, Irvine
252E Berk Hall
Irvine, CA, 92697-3959
Phone: 949-824-4274
Email: siphilli@uci.edu

Lorraine Evangelista Professor, Ph.D., RN, FAAN
Sue & Bill Gross School of Nursing, University of California, Irvine
299E, Berk Hall
Irvine, CA, 92697-3959
Phone: 949-824-9057
Email: l.evangelista@uci.edu

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Conflict of Interests

The Authors declare that there is no conflict of interest.

Justifications for Authorship

Each author made significant contributions to this research and manuscript. This project was established through a strong academy-community partnership spurring many inclusive opportunities among faculty, students and the community. The specific contributions of each author are detailed below:

Dr. Yuqing Guo: developed the Emotional Health Curriculum, designed the research, supervised nursing students to implement Emotional Health Curriculum and to collect child satisfaction and teacher interview data, conducted the data analysis, and drafted and finalized the manuscript.

Dr. Julie Rousseau: established the campus-community partnership, developed the Emotional Health Curriculum, designed the research, supervised nursing students to implement Emotional Health Curriculum and to collect child satisfaction data, revised the manuscript substantially and critically.

Dr. Anna S. Hsu: conducted statistical analyses, wrote the results section of the manuscript and gave the final approval of the manuscript.

Dr. Priscilla Kehoe: provided guidance to interpret data and revise the manuscript substantially and gave the final approval of the manuscript.

Monique Daviss: established campus-community partnership, designed the research, and provided critical feedback on manuscript, and approved the final manuscript.

Sara Flores: facilitated campus-community partnership, designed the research, facilitated the intervention implementation and collection of child satisfaction and teacher interview data, and provided critical feedback on manuscript.

Dr. Patricia Renno: developed the Emotional Health Curriculum, designed the research, and provided critical feedback on manuscript.

Kathleen Saunders: facilitated campus-community partnership, supervised nursing students to implement Emotional Health Curriculum and to collect child satisfaction data, and provided critical feedback on manuscript.

Dr. Susanne Phillips: established the campus-community partnership, supervised nursing students to implement health education and conduct clinical research, and gave the final approval of the manuscript.

Dr. Lorraine S. Evangelista: provided mentorship to interpret data and gave the final approval of the manuscript.

Abstract: High rates of mental health problems in adolescents have been documented. Less is known about elementary school children in disadvantaged community. We examined emotional and behavioral health needs in 202 3rd and 4th graders enrolled in a charter school in a largely Hispanic community. The child-reported Revised Child Anxiety and Depression Scale-25 (RCADS-25) and Teacher's Report Form (TRF) were used to evaluate mental health needs as perceived by these children and their teachers. The prevalence of teacher-reported depression and child self-reported anxiety were 7.0% and 6.67% respectively. Living in a single parent household was found to be a specific risk factor in that those children had higher rates of emotional and behavioral problems than children living with both parents. Evidence of higher depression anxiety identified in this sample compared to national representative data suggests the need for development of culturally-sensitive early prevention and intervention in this underserved community.

Emotional and Behavioral Health Needs in Elementary School Students in an Underserved Hispanic Community

Introduction

The National Research Council (NRC) and the Institute of Medicine (IOM) estimate that 1 out of every 5 children in the U.S. have a mental disorder in any given year with an annual cost of \$247 billion (NRC and IOM, 2009). Anxiety and depression are the most prevalent psychiatric conditions in children and adolescents (Ahlen, Lenhard, & Ghaderi, 2015; Bennett et al., 2015). Conduct disorder and substance use disorder, which can mask or co-occur with depression and anxiety, are common reasons to refer youth for mental health assessment and treatment (Steiner & Rensing, 2007). In a national representative study, the prevalence rates for major depression, conduct disorder, and substance use disorder in adolescents aged 13- 18 years were 11.7%, 6.8% and 11.4%, respectively (Merikangas et al., 2010). In one diverse sample of children aged 4-6 years, the prevalence of major depression (3.1%-4.1%) was lower relative to rates found in adolescent populations (Lavigne, Hopkins, Gouze, & Bryant, 2015).

Studies have substantiated high rates of mental health problems in Hispanic youth (Anderson & Mayes, 2010; Roosa et al., 2011). For example, Mikolajczyk et al., (2007) found that Hispanic adolescents aged 12-17 years old were twice as likely to develop depression as non-Hispanic adolescents using the 2003 California Health Interview Survey data. McLaughlin et al. (2007) investigated the prevalence of emotional and behavioral symptoms in middle school students and the results showed that Hispanic adolescents reported higher separation anxiety symptoms than their White and Black counterparts. Other studies have demonstrated that Hispanic adolescents have higher rates of substance use than non-Hispanic Whites (Johnston, O'Malley, Miech, Bachman, & Schulenberg, 2016; Kann et al., 2016). Furthermore, Saloner et

al. (2014) found that African or Hispanic children and adolescents aged 5 to 17 years had particularly higher rates of unmet needs for mental health services relative to other ethnic children.

While there is considerable information and speculation about mental and behavioral health in Hispanic adolescents, far less is known about mental health problems in Hispanic young children. It is, however, critically important to detect mental health problems early because emotional and behavioral problems in young children can lead to impaired social functioning, poor academic achievement, delinquency, suicidal attempts, and substance abuse in adolescents or adulthood ([Cleverley, Szatmari, Vaillancourt, Boyle, & Lipman, 2012](#); Forman-Hoffman et al., 2016; Maughan, Collishaw, & Stringaris, 2013). Cowell et al. (2005) examined depression in urban 4th and 5th grade Mexican American children in Chicago with self-reported Children's Depression Inventory (CDI) at home. In this study 7.8% of these children had depressive symptoms using a non-clinical cut score of 19 and 31% of them were classified as depressed using the clinical cut point of 12.

The purpose of this study was to examine emotional and behavioral health needs of young children while attending an elementary school in a largely Hispanic community from child and teacher perspectives. Research on emotional and behavioral health of young children stress the need to collect and compare mental health information from multiple sources (De Los Reyes et al., 2015; Rescorla et al., 2014; Ringoot et al., 2015; van der Ende, Verhulst, & Tiemeier, 2012). Our study used a cross-informant approach to identifying mental health needs in our sample of children. Cross informant analyses allow for comparisons in two or more sources of data; in our study it offers a measure of concordance between children self-reports and teacher ratings using different validated measures.

Methods

Design and Setting

We used a descriptive exploratory study design to describe the mental health needs of 3rd and 4th grade children in a K-8 charter bilingual school in the community of Santa Ana, California. Our University research team had formed a strong partnership with this school prior to this study based upon mutual involvement in a 5-year U.S. Health Resources and Services Administration (HRSA) grant. During the five-year collaboration, a general health and reproductive curriculum was designed and implemented for elementary children in the school. Additionally, the school and university hold annual health fairs to serve families in this community. Together, we have observed that some of the school children have exhibited emotional and behavioral problems as documented by their school social worker and school nurse. Teachers and administrators have requested that we identify mental health needs for the purpose of pilot testing an Emotional Health Curriculum for the classroom. High levels of trust and collaboration resulting from the ongoing relationships between the parents, teachers, school administrative leaders, and the research team were essential to the design and implementation of the study.

Study Procedure

The study was approved by the University IRB. Data were collected January 2016. With support from school administrative staff, parents of 3rd and 4th grade students were informed about this study through a Parent Newsletter and a Study Flyer in Spanish. Parents also received a Spanish language version of the Study Information Sheet which provided information such as purpose, study procedure, and participant's rights and benefits prior to data collection. All parents were instructed that they had the right to decide whether they would allow their child to participate in this study by filling out a questionnaire including demographic information and

emotional status. If parents did not want their child to participate in the study, they were told to contact a school staff member who was designated as the study coordinator. During the study period, no parent contacted the study coordinator to refuse to participate or withdraw from the study.

The eight Hispanic teachers of the classrooms of these 3rd and 4th graders received the English language version of the Study Information Sheet. If the teachers had concerns about filling out questionnaires for their students, they were instructed to contact the study coordinator as mentioned above. The first author provided teachers with instructions on how to complete the assessment. All teachers filled out an individual questionnaire to evaluate each of their students. There were 24-26 students in a classroom. Each teacher received \$100 cash in appreciation for their time and effort to complete the questionnaires. Trained research assistants used pre-developed scripts to explain the study procedure to the children prior to administering the English questionnaires in the classrooms at this school. Verbal assent was obtained for students. Six students were absent on the day when the questionnaire was administered and no students refused to participate in the study. Assistance from the trained research assistants was also provided for those children who had difficulty understanding or filling out the questionnaire. Students received a notebook and stickers as rewards for their participation.

Participants

We recruited 202 children from eight classes with 102 and 101 students from the 3rd and 4th grades, respectively. Demographic information for the sample is shown in Table 1. The gender ratio was almost equal with 46.5% girls to 53.5% boys. The children ranged from 8 to 11 years ($M = 8.70$, $SD = 0.65$). Students were primarily Hispanic (170, 84.2%) outnumbering other ethnicities including American Indian or Alaska Native (20, 9.9%), non-Hispanic Whites (9,

4.5%), and African American (1, 0.5%). Most of the students lived with both parents (78.2%) and spoke both English and Spanish at home (76.7%).

Measurements

The Revised Child Anxiety and Depression Scale-25 (RCADS-25; Ebesutani et al., 2012) is a child self-reported instrument assessing both depression and anxiety consistent with DSM-IV (American Psychiatric Association, 2000). The RCADS-25 includes the 15-items that measure general anxiety disorder and 10-items that measure major depression disorder. Children were asked to indicate how often each item applied to them on a 4-point scale (0 = never, 1 = sometimes, 2 = often, 3 = always). For example, questions include: “I feel sad or empty”, “I worry that something awful will happen to someone in my family”. RCADS-25 is a validated instrument in both school-based and clinical-referred samples for children in grades 3-12 and has been used and validated across a wide range of groups including Whites, African Americans, Asian Americans, and Hispanics (Ebesutani et al., 2012). The Cronbach’s alpha for depression and anxiety in this sample were 0.76 and 0.82 respectively.

As instructed by the designers of the measure we summed the raw RCADS-25 scores and converted them to normalized T scores. Using T scores, we classified children into two groups designated as normal, and borderline/clinical. According to RCADS standards, children with RCADS-25 depression and anxiety scores lower than 65 are within normal range, and children with scores equal to or above 65 are considered to be in the borderline/clinical range, (Chorpita, Ebesutani, & Spence, 2015).

The Teacher’s Report Form (TRF; Achenbach & Rescorla, 2001) is a teacher assessment instrument measuring emotional and behavioral problems in children aged 6-18 years which can be used by classroom teachers to evaluate their students. Teachers were asked to rate a student’s

behaviors during the last months on a 3-point scale (0 = not true, 1 = somewhat or sometimes true, 2 = very true or often true). DSM-oriented scales were constructed to be consistent with diagnostic categories of DSM-IV and DSM-V (Achenbach et al., 2017). It includes 54 items assessing six mental health problems: depression, anxiety, somatic complaints, attention deficit/hyperactivity disorder (ADHD), opposition defiant problems, and conduct problems (Achenbach, Dumenci, & Rescorla, 2003). Example items include: “there is very little that he/she enjoys” (depression), “too fearful or anxious” (anxiety), “physical problem: stomach” (somatic complaints), “inattentive or easily distracted” (attention deficit/hyperactivity disorder), “argues a lot” (opposition defiant problems), and “breaks school rules” (conduct problems). The Cronbach’s alpha for the six subscales (depression, anxiety, somatic, ADHD, opposition, and conduct) in this sample was 0.80, 0.64, 0.54, 0.90, 0.83, and 0.76, respectively.

The raw scores were summed and transformed into T scores. Using T scores, we used data on teacher perceptions to classify children into two groups (normal, borderline/clinical). According to TRF standards, children with subscale scores lower than 65 are classified in the normal group, children with scores are equal to or above 65 are in the borderline/clinical group, (Achenbach & Rescorla, 2001; Achenbach et al., 2003).

Analysis

We used the IBM SPSS version 22.0 for Windows software (SPSS, Inc., Chicago, IL, USA) to conduct statistical analyses. Descriptive statistics were used to describe the demographic characteristics of the children. Frequencies and percentages were calculated to describe the prevalence of emotional and behavioral problems in these children and agreement on ratings between child self-reported and teacher-reported assessments of depression and anxiety in terms of collapsed borderline and clinical categories. Pearson correlations were

conducted to examine the associations between child and teacher ratings. One-way ANOVA was used to examine whether emotional and behavioral problems differed significantly with regard to grade, gender, ethnicity, and family living status. Given 84.2% of children were Hispanic and 78.2% lived with both parents, we created dichotomy groups for ethnicity (Hispanic vs. non-Hispanic) and family living status (living with both parent vs. living with one parent) in ANOVA analyses.

Results

The purpose of this study was to examine emotional and behavioral health needs of young children attending an elementary school in a largely Hispanic community from teacher and child perspectives. The child self-reported results showed that 11 (5.61%) had borderline/clinical range for depression and 13 (6.67%) anxiety. Among these children, six (3.1%) had both depression and anxiety. The teacher-reported results demonstrated that 14 (7.0%) children had borderline/clinical range for depression and 11 (5.5%) anxiety. Among these children, five (2.5%) had both depression and anxiety (see Table 2). Teachers also reported 6 (3.0%) children had somatic problems, 8 (4.0%) ADHD, 9 (4.5%) oppositional defiant problems, and 5 (2.5%) conduct problems.

Among 196 children with both self-reported and teacher-reported assessments, children and teachers agreed that four children (2.05%) had depression and only one (0.52%) anxiety (see Figure 1). The correlations between child-reported and teacher-reported depression and anxiety were low ($r = 0.29, p < .001, r = 0.15, p < .001$), respectively.

As shown in Table 3, child self-reported depression and anxiety differed by grade, gender, and living status with parent. Third graders reported significantly higher depression compared with fourth graders; girls had significantly greater depression and anxiety than did

boys; children living with a single parent had significantly higher depression and anxiety compared with children living with both parents. Although the child self-reported depression and anxiety were observed to be higher in Hispanic children than were non-Hispanic children, the observed differences were not significant.

Table 4 reveals that teacher-reported problems differed by grade, gender, ethnicity, and living status with parent. Teachers reported that fourth graders had significantly higher anxiety and conduct problems than did third graders. The significant gender differences were revealed only in behavioral defiant problems in that boys had higher scores than did girls. Teachers reported significantly greater oppositional defiant problems in non-Hispanic children than Hispanics children. Children living with a single parent had significantly higher depression for both child self-reported and teacher-reported assessments.

Discussion

The key findings of our study showed that elementary children had relatively high prevalence of depression and anxiety in a primarily Hispanic community from both child and teacher perspectives compared with the national representative data. We also discovered that there were different patterns in emotional and behavioral problems by grade, gender and ethnicity between child and teacher perspectives. However, child and teacher assessments shared the same pattern of family status in that children living with a single parent had greater emotional and behavioral problems than did children living with both parents. To our knowledge, our study is one of the few to examine emotional and behavioral problems of elementary students from the perspective of both the children and teachers in a community primarily serving Hispanic families in the U.S.

Compared with the national representative sample in depression and anxiety (2.7% and 0.7%) in children aged 8 to 15 years using Diagnostic Interview Schedule for Children, our results found higher rates of teacher reported depression (7.0%) and child self-reported anxiety (6.67%). Toppelberg et al., (2013) also used TRF (the same instrument as our study) to assess internalizing symptoms (depression, anxiety and somatic complaints) in 5-to-7 year old Hispanic children (52% mother's birth place from Dominica Republic and 21% from Puerto Rico) in a large urban school district of northeast United States. We calculated the internalizing score in order to make comparison with Toppelberg's study. Although our study sample had fewer single families (13.4% vs. 47% in Toppelberg's study) primarily from Mexico, the internalizing symptoms revealed in our study was almost twice as identified in Toppelberg's study (9.4% vs. 4.9%). The studies examining emotional and behavioral problems in Hispanic children have been largely either preschoolers/kindergartens or early adolescents (Caughy, Peredo, Owen, & Mills, 2016; Potochnick & Perreira, 2010; Stein, Gonzalez, & Huq, 2012; Toppelberg, Hollinshead, Collins, & Nieto-Castañon, 2013). Our findings provide the preliminary evidence of mental health needs for elementary children aged 8 to 11 years largely from Hispanic families.

The low agreement on depression and anxiety between children and teachers found in our study supports previous research. Worchel et al. (1990) investigated the concordance between Children's Depression Inventory and Teacher's Report Form (depression subscale). The results showed that low correlation ($r = 0.13, p < 0.01$) was found between child self-report and teacher-report in 5th, 6th and 9th graders with 18% of children being Hispanic and 78% of being non-Hispanic White (Worchel et al., 1990). In a study by Auger et al. (2004), teachers' ratings of students' depression also had low correlations ($r = 0.22, p < 0.001$) with students' self-reported depression in children from 6th to 8th grades with 25% students being non-White. More recently,

these findings of low agreement on depression between child's self-report and teacher's report were replicated in children by Cole et al. (2017) and Woo et al. (2007). Our findings in mostly Hispanic population demonstrate the similar discrepancy in ratings of internalizing problems between teachers and children.

The striking finding of our study is that both children and teachers shared the similar perceptions that children living with a single parent had higher depression and anxiety compared with children living with both parents. Our findings are consistent with growing evidence that children living with a single parent were more likely to experience mental health problems (Astrup, Pedersen, Mok, Carr, & Webb, 2017; Perales, Johnson, Baxter, Lawrence, Zubrick, 2017). Scharte et al. (2013) also found that children from a single mother family demonstrated significantly higher mental health problems than those with both parents. They reported that single families were more often exposed to disadvantaged socio-economic characteristics such as low education and income which may have had an impact on the child's health status. Together, these results suggest that it is important to include family status as a risk factor for assessing mental health needs.

Our study found that gender had differential impact on child and teacher perceptions of students' emotional and behavioral problems. Girls perceived themselves to have higher depression and anxiety than did boys. Our findings are consistent with one study using self-reported assessment in Hispanic children aged 13-18 years (Céspedes & Huey, 2008). There are other studies which did not find gender differences in child-reported depression and anxiety in Hispanic adolescents (Stein et al. 2012; Potochnick & Perreira, 2010). We also found that teachers perceived that girls and boys had similar rates of depression and anxiety. The results are in the same line with Auger et al. (2004) study which discovered that student's gender did not

impact teachers' perception of students' depression. Our study provides initial evidence as to the effect of child gender on depression and anxiety in primarily Hispanic children from both child and teacher perspectives. Further studies are needed to clarify the mixed results through examining how gender impacts mental health problems in Hispanic children using multiple-informants' approach.

Limitations and Future Studies

There are four limitations that warrant attention. First, A clinical diagnosis would be helpful to further examine discrepancy of ratings between teacher and student. Second, we did not use parent reports of children's mental health. Some studies show that children's behaviors display differently across home and school (Dirks, De Los Reyes, Briggs-Gowan, Cella, & Wakschlag, 2012; Gross, Fogg, Garvey, & Julion 2004). Inclusion of parent-reported assessments would capture emotional and behavioral problems occurred at home, comparison to school behaviors in future studies. Third, we did not collect full information on social-economic status (SES) such as parent education, immigrant status, and acculturation. For example, Landale et al. (2015) showed that children of undocumented Mexican mothers had significantly higher elevated internalizing and externalizing behaviors than counterparts who were naturalized citizens or documented mothers. Fourth, our study was conducted with 3rd and 4th graders in one charter school. The generalization of our results is thus limited. Future studies are needed to have mental health clinicians validate reports from children, teachers and parents. Including comprehensive SES information would be helpful to better understand how mental health problems in young children differ as a function of parent and family demographic characteristics. Data from elementary children across different schools in the U.S. Hispanic communities would test the generalizability of these results.

Implications for School Nursing Practice

The National Association of School Nurses (NASN) emphasizes that mental health status can influence a child's emotional, social and academic competency (NASN, 2013). It is thus crucial for school nurses to serve as advocates and facilitators in the assessment and identification of children in need of mental health intervention, referral, and follow-up services (NASN, 2013). Our study provides empirical evidence describing emotional and behavioral health needs in elementary school children in a largely Hispanic community from child and teacher perspective. While recent research emphasizes that implementation of school-based mental health screening is an important approach to reducing mental health disparities for children and adolescents, the different perspectives on internalizing problems between children and teachers in our study suggest that school nurses should implement cross-informant screening including both children and teachers as well as parents (Nemeroff et al., 2008; Prochaska, Le, Baillargeon, & Temple, 2016).

School-based prevention is one of important approaches to reducing barriers to mental health care such as financial barriers where parents cannot afford health insurance, transportation barriers where parents cannot take children to appointments, and sustainability barriers where children cannot be taken for appointments regularly (Kataoka, Novins, DeCarlo Santiago, 2010; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). NASA speculates that school nurses play a crucial role in addressing mental health disparities by working with children, families, school leaders, and community health care professionals (NASA, 2016). The high depression and anxiety problems detected in largely Hispanic young children from our study underscores the need for an early prevention and intervention program. A growing body of evidence supports the effectiveness of school-based cognitive behavioral therapy (CBT) programs in preventing

anxiety and depressive symptoms (Calear & Christensen, 2010; Neil & Christensen, 2009) Tamika, et al.,(2017) also found dialectical behavioral therapy had potential to reduce risky behaviors in early adolescents Together, evidence suggests that school nurses should actively promote culturally sensitive school-based mental health programs to provide a safe place to communicate children's emotional experiences and equip children's coping skills to manage their distress in Hispanic communities.

In summary, our results highlight the importance of fully understanding the mental health needs in this population and provide beginning support for developing and implementing school-based early prevention and intervention programs to address mental health disparities in this underserved community.

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Table 1*Descriptive Characteristics of School Children in Study Sample (N = 202)*

Variables	<i>n</i>	%
Gender		
Boys	108	53.5
Girls	94	46.5
Age (year)		
8	80	39.6
9	103	51.0
10	18	8.9
11	1	0.5
Grade level		
3rd	102	50.5
4th	100	49.5
Ethnicity		
Hispanic	170	84.2
Non-Hispanic White	9	4.5
Black or African American	1	0.5
American Indian or Alaska Native	20	9.9
Not Reported	2	1.0
Language spoken at home		
Spanish	27	13.4
English	13	6.4
Spanish and English	155	76.7
Not Reported	7	3.5
Lives with		
Both parents	158	78.2
One parent	27	13.4
Other	7	3.5
Not Reported	10	5.0

Table 2*Prevalence of Emotional and Behavioral Problems as Reported by Students and Their Teachers*

Variables	Normal		Borderline/Clinical	
	<i>n</i>	%	<i>n</i>	%
Child-reported RCADS ^a				
Depression	185	94.39	11	5.61
Anxiety	182	93.33	13	6.67
Teacher reported TRF ^b				
Depression	186	93.00	14	7.00
Anxiety	189	94.50	11	5.50
Somatic	194	97.00	6	3.00
ADHD	192	96.00	8	4.00
Oppositional	191	95.50	9	4.50
Conduct	195	97.50	5	2.50

Note. ^a RCADS = Revised Child Anxiety Depression Scales. ^b TRF = Teacher Report Form. For child-reported RCADS scores, six children were missing depression scores and seven children were missing anxiety scores. For each of the subscales on TRF, two children were missing scores.

Table 3*Differences by Demographic Factors in Child Self-reported RCADS-25 Depression and Anxiety*

	Depression		Anxiety	
	<i>n</i>	Mean (SD)	<i>n</i>	Mean (SD)
Grade ^a				
3rd	97	49.08 (8.92)	96	48.91 (9.27)
4th	99	45.32 (11.05)**	99	47.06 (11.28)
Gender ^b				
Boys	104	45.17 (9.08)	103	45.76 (10.48)
Girls	92	49.46 (10.95)**	92	50.44 (9.68)***
Race/Ethnicity ^c				
Hispanic	167	47.36 (9.96)	167	48.32 (10.24)
Non-Hispanic	27	44.77 (9.87)	26	45.41 (9.97)
Family Status: Living with ^d				
Both Parents	158	46.08 (9.51)	158	47.36 (10.16)
Single Parent	27	52.79 (12.46)**	26	51.37 (11.85)*

Note.

^a Reference group = 3rd grade. ^b Reference group = Boys.

^c Reference group = Hispanic. ^d Reference group = living with both parents.

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

Table 4

Differences by Child Demographic Factors in Teacher-reported Student Emotional and Behavioral Problems

		Depression	Anxiety	Somatic	ADHD	Opposition	Conduct
		M(SD)	M(SD)	M(SD)	M(SD)	M(SD)	M(SD)
Grade^a							
3rd	101	53.25 (6.82)	52.44 (5.59)	51.61 (4.71)	53.03 (5.55)	52.23 (4.46)	51.44 (3.37)
4th	99	53.13 (5.57)	54.07* (5.32)	51.04 (3.86)	52.95 (4.27)	52.64 (5.63)	53.27** (4.85)
Gender^b							
Boys	108	53.15 (5.58)	52.81 (5.65)	51.44 (4.62)	53.04 (5.18)	53.11* (4.95)	52.29 (3.82)
Girls	92	53.24 (6.92)	53.76 (5.31)	51.20 (3.93)	52.93 (4.70)	51.63 (5.11)	52.41 (4.74)
Race/Ethnicity^c							
Hispanic	168	53.01 (5.88)	52.95 (5.28)	51.11 (3.86)	52.71 (4.50)	51.93 (4.33)	52.09 (4.09)
Non-Hispanic	30	53.17 (5.75)	54.40 (5.96)	51.83 (4.81)	53.30 (5.12)	54.67** (7.54)	53.20 (4.39)
Family Status: Living with^d							
Both Parents	157	52.32 (5.24)	52.95 (5.39)	50.95 (3.77)	52.08 (3.58)	51.76 (3.83)	51.73 (3.58)
Single Parent	27	57.26*** (8.68)	55.15† (6.35)	52.67† (6.10)	56.56*** (7.22)	56.15*** (8.76)	55.96*** (6.19)

Note. ^a Reference group = 3rd grade. ^b Reference group = Boys. ^c Reference group = Hispanic. ^d

Reference group = living with both parents.

† $p < .10$. * $p < .05$. ** $p < .01$. *** $p < .001$.

Figure 1. Agreement between Student Self-reported and Teacher-reported Depression and Anxiety in the Study Sample