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Anxiety, Depression, and Coping Skills Among Mexican School Children: A Comparison of Students With and Without Learning Disabilities

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Abstract

The purpose of this study was to compare severity and risk status for anxiety and depression with coping skills among 130 Mexican school children with learning disabilities (LD) and 130 school children without LD. This research is the first to explore the emotional difficulties of Mexican children with LD. Children completed the Spanish version of the *Spence Children's Anxiety Scale* and *Children's Depression Inventory*, and the *Cuestionario de Afrontamiento (Coping Skills Questionnaire)*. Results indicated that a higher percentage of children with LD were at risk for anxiety (22.3% vs. 11.5%) and depression (32% vs. 18%). No statistically significant differences were found for coping skills. Results support the idea that there is an increased awareness of comorbid depression and anxiety among students with LD and a need to promote early identification and intervention in schools. Efforts should focus on better understanding the relationship between social-emotional difficulties and academic achievement and on developing effective interventions to support children with LD.

Keywords

anxiety; depression; learning disabilities; elementary school

Anxiety disorders, which affect 10% to 20% of children, are the most prevalent form of psychopathology in childhood. They have been identified as a salient mental health concern, particularly because anxiety can be associated with depression, deviant conduct, and substance abuse (Caraveo-Anduaga & Comenares-Bermúdez, 2002; Costello et al., 2002; Kendall & Suveg, 2006), as well as interference with school, social, and familial functioning (Langley, Bergman, McCracken, & Piacentini, 2004). According to a recent study conducted in Mexico, approximately 40% of Mexican adolescents, ages 12 to 17, have a mental health disorder, with anxiety disorders being most commonly reported, followed by impulse-control disorders, mood disorders, and substance abuse (Benjet, Borges, Medina-Mora, Zambrano, & Aguilar-Gaxiola, 2009). During adulthood, anxiety disorders have also been reported as the most prevalent form of psychopathology both in the United States and in Mexico (Kessler et al., 2005; Medina-Mora et al., 2003). Medina-Mora et al. (2003)

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reported that after anxiety disorders, affective disorders (e.g., depression) and substance abuse are the most common mental health problems experienced in Mexico.

Children with learning disabilities (LD) perform substantially lower than what is expected based on intelligence and age (Fletcher, Morris, & Lyon, 2004), and previous studies suggest that children with LD are predisposed to social and emotional difficulties (Elksnin & Elksnin, 2004; Forness, Walker, & Kavale, 2003; Kavale & Moster, 2004; Margalit & Zak, 1984; Sharma, 2004; Svetaz, Ireland, & Blum, 2000). Therefore, this group of children may be at greater risk for anxiety and depressive disorders when compared with their typically developing peers.

Low achievement has been related to school failure and poor academic and emotional skills (Margalit & Zak, 1984; Patten, 1983), and school failure is a distinct characteristic of children with LD (Martinez & Semrud-Clikerman, 2004). Different explanations have been raised for the relationship between school failure and poor academic and emotional functioning (Greenham, 1999; Sundheim & Voeller, 2004). Some researchers suggest that both social and learning impairments are caused by a deviation in the functioning of the central nervous system called *atypical brain development* (Kaplan, Dewey, Crawford, & Wilson, 2001; Rourke & Fuerst, 1991); others suggest that chronic school failure triggers emotional difficulties (Patten, 1983). There is also the hypothesis that the problems compound one another (Al-Yagon & Mikulincer, 2004; Martinez & Semrud-Clikerman, 2004).

Affective variables such as self-concept, attributions, motivation, anxiety, temperament, loneliness, and depression have been studied in children with LD, with most studies reporting that children with LD experience difficulties in these areas (Bender & Wall, 1994; Lackaye, Margalit, Ziv, & Ziman, 2006; LaGreca & Stone, 1990; Manassis & Young, 2004; Margalit & Al-Yagon, 2002; Mayron, 1978; Sundheim & Voeller, 2004). Children with LD frequently show characteristics such as behavioral inhibition and maladaptive cognition, which lead to anxiety (Al-Yagon & Mikulincer, 2004). Expressions of anxiety in the form of crying and worrying, symptoms of somatic distress, and avoidant behavior have often been reported for students with LD (Margalit & Heiman, 1986). Several studies have concluded that children with LD, when compared to typically developing peers, show higher levels of anxiety and helplessness (Margalit & Zak, 1984; Rodriguez & Routh, 1989; Sharma, 2004). Similarly, research suggests that children with LD are more likely to show higher levels of loneliness and depression than their typically developing peers (Margalit, 2006; Newcomer & Barenbaum, 1995). Studies have found that children with LD, particularly girls, frequently experience higher levels of negative mood, lower levels of positive mood, and higher levels of depression (Heath & Ross, 2000; Lackaye et al., 2006; Maag & Reid, 2006; Martinez & Semrud-Clikerman, 2004; Sundheim & Voeller, 2004).

Rodriguez and Routh (1989) investigated depression, anxiety, and attributional style in children with LD and typically developing children. Sixty-two children, ranging from 8 to 13 years old, were assessed with the *Children's Attributional Style Questionnaire* (CASQ), the *Children's Depression Inventory* (CDI), the *Revised Children's Manifest Anxiety Scale* (RCMAS), the *Anxiety-Withdrawal of the Revised Behavior Problem Checklist* (RBPC), and the *Peer Nomination Inventory of Depression*. Results showed that children with LD reported significantly more anxiety on both anxiety measures than the control group. Furthermore, children who were diagnosed with LD for a longer period of time reported higher levels of anxiety and peer-nominated depression when compared to both control group and children who were recently diagnosed with LD (Rodriguez & Routh, 1989).

The literature on coping skills of children with LD is scarce, but the characteristics of these children suggest that they may have difficulties using proactive coping skills when facing problems and challenges (Mohr et al., 1980). A study by Dietrich and Kelly (1993) concluded that high school students with learning disabilities reported inconsistent effort and inadequate use of compensatory skills. The academic skills reported by the participants of this study ranged from sporadic to absent, as when experiencing a difficulty they made little effort to contact a high school teacher (Dietrich & Kelly, 1993).

Although learning disabilities account for about 50% of the cases referred to special education in Mexico (Fletcher, 1990; Secretaría de Educación Pública, 2002), so far there has been no investigation published in a peer-reviewed journal concerning anxiety, depression, and coping skills among Mexican children with LD. The purpose of this study was to compare the severity of anxiety symptoms and risk status for anxiety, the severity of depressive symptoms and risk status for depression, and coping skills among Mexican students with learning disabilities and their peers without learning disabilities.

Method

Participants

Participants were fourth- and fifth-grade children 9 to 12 years old ($M = 9.9$ years) attending eight schools in a city of the northern region of Mexico. Schools were randomly selected and were all representative of Level 6 socioeconomic status (SES), a metric used by the Instituto Nacional de Estadística y Geografía (National Institute of Geography and Information in Mexico) and accounting for 70% of the population. Level 6 represents low SES.

Socioeconomic status—Level 6. In Level 6, 91.83% of the population can read and write, 91.85% of the population ages 6 to 14 go to school, 69.82% of the population ages 12 to 17 go to school, 49.91% of the population over 15 years old have post primary education, 30.73% of the working population earns more than two and a half minimum salary wages per day (the minimum salary is \$53.26 Mexican pesos, which equals \$4.23 USD), and only 9.24% of the population earns more than five salary wages per day (Instituto Nacional de Estadística y Geografía, 2006). Schools were coeducational, inclusive settings for students with LD, had at least two classrooms at each grade 4 and 5, and were served by the Gabinetes de Servicios Educativos (Office of Educational Services), a unit within the Special Education Department of the State that provides services to the regular primary schools. The sample for this study was part of a larger study (see Gallegos, 2008).

Identification of learning disabilities—Children with LD were identified through school records. In Mexico, students are identified as LD if (a) they are below the 25th percentile in academic achievement, (b) the learning disability is not due to other conditions such as sensory or physical handicaps, (c) academic difficulties persist after the classroom teacher provides adequate instruction, and (d) students are referred, evaluated, and identified with LD by the Gabinetes de Servicios Educativos. The cases referred to Gabinetes de Servicios Educativos are evaluated by a multidisciplinary team composed of a psychologist, an educator, a speech therapist, a social worker, and a medical doctor. The assessment conducted by the educator is based on the Psychogenetic Theory of Jean Piaget, where the educator determines the developmental level, especially in reading and mathematics. The educator also takes into account the academic history through a semistructured interview with parents.

A student is identified as having LD if his or her performance is below his or her developmental level. The psychologist conducts an interview with the student and the

parents to gather information about his or her clinical history, emotional state, psychomotor development, and interpersonal relationships. The psychological tests applied are the *Bender Visual Motor Gestalt Test* and the *Draw a Person Test* by Karen Machover. In the psychology area they analyze the emotional factors that might affect learning. The speech therapist evaluates the pragmatic, syntactic, semantic, and phonological aspects of language. The social worker revises the family and community aspects that might be affecting the student's learning. And finally, the medical doctor analyzes if the student presents a visual, hearing, or other impairment. With this information, the multidisciplinary team gets together to provide the diagnosis of having a "learning disability" (Secretaría de Educación Pública, 2002).

sample selection—For this study, only those participants who had completed the three self-report questionnaires of anxiety, depression, and coping skills were included. There were initially 831 children without LD and 130 children with LD. Before doing the random assignment to select 130 children without LD, chi-square analyses were conducted to ensure that there were no statistically significant differences between children with and without LD for age, grade, and gender. Chi-square analyses revealed that there were no statistically significant differences for age, $\chi^2(3, n = 961) = 3.45, p > .05$, and grade, $\chi^2(1, n = 961) = 0.72, p > .05$. There were statistically significant differences for gender, $\chi^2(1, n = 961) = 16.20, p < .05$.

Therefore, the random selection of the 130 cases from the group without LD was conducted within gender cells. The final sample consisted of 260 children: 130 children with LD and 130 children without LD. Eighty-three of the children with LD were boys (63.85%) and 47 were girls (36.15%); 63 were in Grade 4 (48.5%) and 67 were in Grade 5 (51.5%). The age range of children with LD was from 9 to 12 years, with a mean age of 9.97 years ($SD = 0.82$). Eighty-three children without LD were boys (63.85%) and 47 were girls (36.15%); 76 were in Grade 4 (58.5%) and 54 were in Grade 5 (41.5%). The age range of children without LD was from 9 to 12 years, with a mean age of 9.91 years ($SD = 0.82$). Chi-square analyses for the final sample reported that both groups were comparable in age, $\chi^2(1, n = 260) = 2.61, p > .05$; grade, $\chi^2(1, n = 260) = 0.40, p > .05$; and gender, $\chi^2(1, n = 260) = 0, p > .05$. Children in both groups, with LD and without LD, were Mexican, were from a low SES family, and lived in an urban area.

Measures

Three measures were administered collectively to all children during school time to determine the severity of anxiety and depressive symptoms if present, the risk status for anxiety and depression, and coping skills. Trained teachers and psychologists from the office of Gabinetes de Servicios Educativos read the instructions and test items aloud to all students and answered questions. Anonymity was assured.

Spence Children's Anxiety Scale—The Spanish version of the *Spence Children's Anxiety Scale* (SCAS; Spence, 1997) is a self-report measure of anxiety designed for use with children from 8 to 12 years old. The SCAS consists of 44 items, 38 of which assess specific anxiety symptoms (e.g., symptoms of social phobia, separation anxiety, panic attack, and agoraphobia). The remaining 6 items serve as positive "filter items" to reduce negative response bias. Children are asked to rate, on a 3-point scale (0 = *never* to 2 = *always*), the frequency with which they experience each symptom. The total score of this measure was used in the current study. Spence (1997) has reported high internal consistency ($r = 0.92$), high split-half reliability ($r = 0.90$), adequate test-retest reliability ($r = 0.60$), and support for convergent and divergent validity. This measure has been translated into Spanish and standardized with a normative sample of students from Mexico showing sound

psychometric properties including a reliability coefficient of 0.91 on the SCAS scores (Bermúdez-Ornelas & Hernández-Guzmán, 2002; Hernández-Guzmán et al., 2010). For the current study, participants were categorized as either high or low risk for anxiety using a cutoff score of 41, determined by adding 1 standard deviation (10.95) to the SCAS mean score (30.22) of the sample from the larger study ($N = 931$; Gallegos, 2008).

Cuestionario de Depresión Infantil—The Spanish version of the *Children's Depression Inventory* (CDI; Kovacs, 1981) is a self-report measure used for depressive symptoms in children ages 7 to 17 years. The CDI has 27 items related to the cognitive, affective, and behavioral signs of depression. Each item contains three statements, and children select the one that best describes them in the past 2 weeks. Statements within each item are scored according to the severity of child's symptoms (0 = *no symptomatology present*, 1 = *mild symptomatology*, 2 = *severe symptomatology*). A total score is calculated by adding the statements chosen by the students. The statement (Item 9) that assessed suicidality was removed. The CDI has shown good psychometric properties: a Cronbach's alpha reliability coefficient of 0.94 and a test-retest reliability coefficient of 0.87, and adequate construct and content validity (Del Barrio, Moreno-Rosset, & López-Martínez, 1999; Saylor, Finch, Spirito, & Bennett, 1984). For purposes of the current study, participants were categorized as either high or low risk for depression using a cutoff score of 15, determined by adding 1 standard deviation (5.36) to the CDI mean score (9.39) of the sample from the larger study ($N = 931$; Gallegos, 2008).

Cuestionario de Afrontamiento—The *Coping Skills Questionnaire* (CA; Hernández-Guzmán, 2003) is a Spanish measure developed and standardized in Mexico to assess coping skills in children. It is a self-report measure for children aged 6 to 12 years. The scale has 12 items related to the child's interpretation and reactions when facing a problem, and the things he or she does to cope with and/or solve the problem. Lower scores reflect high proactive positive coping. Children are asked to rate the frequency with which they experience each statement on a 3-point scale (0 = *never* to 2 = *always*). The questionnaire assesses coping responses to situations perceived as stressful and provides information on three factors: active coping, emotional coping, and passive or avoidant coping. The *Cuestionario de Afrontamiento* has demonstrated adequate psychometric properties including a Cronbach's alpha reliability coefficient of 0.67 (Hernández-Guzmán, 2003).

Statistical Analyses

To compare severity of anxiety and depressive symptoms and coping skills between children with LD and their peers without LD, independent samples t tests were performed for each outcome measure. Chi-square analyses were conducted on the SCAS and CDI to examine the differences in the percentages of children at risk for anxiety and at risk for depression. All data analyses were performed using SPSS version 11.5.

Results

Means and standard deviations for each outcome measure are presented in Table 1 for participants with and without LD. The results from the independent samples t tests revealed a statistically significant difference between children with and without LD on the severity of their anxiety symptoms based on the SCAS mean score, $t(258) = -2.42$, $p < .05$, with children with LD reporting higher anxiety scores than children without LD. Similar results were found for depression, with the independent samples t tests revealing a statistically significant difference between children with and without LD on the severity of their depressive symptoms based on the CDI mean score, $t(258) = -2.23$, $p < .05$; the severity of

the depressive symptoms of children with LD was higher when compared with the children without LD.

Statistically significant differences were also found in the frequency of children at risk for anxiety and depression, with 22.3% of the children with LD at risk for anxiety compared to only 11.5% of the children without LD. The chi-square analysis reported that this difference was statistically significant, $\chi^2(1, n = 259) = 5.36, p < .05$. With regard to risk for depression, frequencies showed that 32% of children with LD were at risk for depression when compared to only 18% of those children without LD. The chi-square analysis reported that this difference was statistically significant, $\chi^2(1, n = 259) = 4.85, p < .05$. No statistically significant differences were found between children with and without LD on their coping skills based on the *Cuestionario de Afrontamiento*, $t(258) = 0.56, p > .05$.

Discussion

Anxiety and depression are common problems experienced by children and adolescents and, if untreated, may lead to a broad range of negative consequences for the child and his or her family (World Health Organization, 2004); hence, early identification and intervention programs are critical. Providing such programs in schools may increase access to children in need of mental health services by overcoming issues of stigma, transportation, and so on and reduce the number of youth whose mental health issues go untreated.

The purpose of this study was to compare the severity of anxiety symptoms and risk status for anxiety, the severity of depressive symptoms and risk status for depression, and coping skills among Mexican students with LD and their typically developing peers. In line with results of previous studies (i.e., Manassis & Young, 2004; Margalit & Zak, 1984; Svetaz et al., 2000), the results from the current study demonstrate that Mexican children with LD are at higher risk for anxiety and depression than their typically developing peers.

Some studies have shown that children with LD have major difficulties in social information processing and reported consistent difficulties understanding complex emotions (Bauminger, Schorr Edelsztein, & Morash, 2005; Margalit, 2004). Therefore, it is likely that they might experience a low ability and avoidance to cope with unpleasant feelings such as anxiety and depression (Margalit & Al-Yagon, 2002; Rock, Fessler & Church, 1997).

Also, due to their poor social adjustment, children with LD are at risk for victimization and bullying (Greenham, 1999). They are more likely to be bullied due to the stigma associated with LD and to have fewer friends and are frequently teased (Martinez & Semrud-Clikerman, 2004; Minsha, 2003). Peer victimization may create adjustment problems and anxiety; rejection from their peers may create a sense of loneliness that, when taken in a passive way, can raise a depressive disorder (Minsha, 2003; Weiner, 2004).

Some children with LD also exhibit an apprehensive temperament (Margalit & Al-Yagon, 2002), which has been shown to be less persistent as a result of school frustration, showing limited flexibility and adaptability and increased risk for anxiety and depression (Rock et al., 1997; Teglasi, Cohn, & Meshbesher, 2004).

The finding that coping skills did not appear to differ between children with and without LD may support recent research that has found that the style of response to difficulty of a student who has LD is independent of his or her level of learning disability (Nuñez et al., 2005; Sideridis, Mouzaki, Simos, & Protopapas, 2006). In their study, Nuñez et al. (2005) obtained data showing that students with LD are not homogeneous with respect to their attributions for academic successes and failures, as some students reported an adaptive profile and some a helplessness profile. Sideridis et al. (2006) explored how motivation,

emotions, and psychopathology play a pivotal role in explaining the achievement tendencies of students with LD. In their study there were two groups of students with reading comprehension difficulties; half of them appeared to be motivated and to have high levels of positive affect and low levels of psychopathology. The other half of the students was lacking the motivation to achieve and had high levels of negative affect and psychopathology. Nuñez et al. (2005) reported that these differences can be explained by the different profiles of the children with LD, where personal characteristics play a very important role for the development of adaptation and coping skills.

Limitations

The results of this study should not be overgeneralized as there are several limitations encountered in this research. First, the sample size included only Grade 4 and 5 students; therefore, further replications are needed with students of other grade levels and also comparing the results by gender. Second, the study included only self-report measures, thus relying only on the children's subjective experience. Children may find it difficult to report, in an accurate way, their thoughts and emotions and may not want to disclose this information. Third, only one protective factor measure was incorporated.

Further Research

Further research should incorporate a broader range of ages and include multiple informants to analyze high concordance and to increase the external validity of the findings. Assessments should incorporate more protective measures such as positive future outlook, self-esteem, and social support, keeping in mind the importance of resilience research (Margalit, 2006). It will be interesting to closely explore the coping styles among children with LD. Comparisons of risk and protective factors between genders should also be explored. This study would have benefited from a qualitative component concerning children's experiences on aspects such as friendships, family dynamics, coping with daily stressors, and bullying, among others. Focus groups and narratives could be used to explore these interesting topics.

Implications for Practice

The current study provides evidence that the percentage of children with LD experiencing risk for anxiety (22.3%) and risk for depression (32%) is high, thus highlighting the importance of early identification and intervention. Given that children with LD account for approximately 50% of the cases referred to the Special Education Department in Mexico (Secretaría de Educación Pública, 2002), it is imperative that awareness be raised among educators and special education teachers about these issues. This may be accomplished by including some of the work from prevention and mental health professions in the pre-service and ongoing in-service training for teachers and rehabilitation professionals in the field of special education (McReynolds & Garske, 2003). The field of LD should envision the possibility of integrating social-emotional and academic interventions, as treating the affective, cognitive, and academic abilities as separate domains has not been effective (Price, Johnson, & Evelo, 1994).

Educating the school community about the prevention of these problems and the importance of social and emotional well-being is imperative not only because many children with LD are struggling with these problems but also because teachers and parents often have difficulty noticing these problems, as they are not as visible as conduct disorders or attention-deficit/hyperactivity disorder (Dadds, Spence, Holland, Barrett, & Laurens, 1997; Lowry-Webster, Barrett, & Dadds, 2001).

Early identification and intervention is critical as, world-wide, very few of those who experience difficulties with anxiety and depression receive treatment (Lowry-Webster et al., 2001; Patel & Moss, 1993). In fact, Benjet et al. (2009) found that less than 14% of those Mexican adolescents in need of mental health services over the past 12 months had actually received any treatment for their disorder (treatment was defined as psychological treatment, calling a telephone helpline, visiting a medical doctor, or relying on a self-help book). Early identification and referral in schools may affect the lives of children with LD experiencing anxiety or depressive symptoms, as it would be more likely that their developmental pathways for anxiety and/or depression could be altered.

Children with LD should be an important target population for selective prevention programs. It is evident that these children may benefit from extra support related to their social and emotional functioning, which could be implemented via individual, small group, or even class room wide programs and involve parents to the extent possible. It is clear that effective interventions are critical in that the longer children with LD continue experiencing feelings of frustration and disappointment, as well as potential anxiety and depression, the higher the risk for academic difficulties in the future (Lackaye et al., 2006).

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Table 1

Means and Standard Deviations for Participants With and Without Learning Disabilities (LD) on Three Measures

Measure	Group	n	M	SD	SE
SCAS	children w/o LD	130	28.88	9.46	0.83
	children w/ LD	130	31.95	10.89	0.95
CDI	children w/o LD	130	9.36	5.60	0.49
	children w/ LD	130	10.97	6.00	0.53
CA	children w/o LD	130	10.18	2.52	0.22
	children w/ LD	130	10.01	2.57	0.23

Note: SCAS = *Spence Children's Anxiety Scale* (Spence, 1997); CDI = *Children's Depression Inventory* (Kovacs, 1981); CA = *Cuestionario de Afrontamiento [Coping Skills Questionnaire]* (Hernández-Guzmán, 2003).