Original Article

Emotional and Behavioral Problems of Afghan Refugees and War-Zone Adolescents

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Objective: Wars' stress and violence can have tremendous effects on children's and adolescents' health and general well being; it may result in patterns of bio-psychosocial problems. The goal of this study was to compare emotional and behavioral problems in Afghan refugees and war-zone adolescents.

Method: One hundred and eighty high school students (90 students in the refugee group and 90 in the war-zone group) in Harat were included in this research. All participants completed the Youth Self-Report (YSR). War zone and refugee adolescents were compared based on their scores on different scales of behavioral and emotional problems.

Results: War-zone adolescents scored significantly higher on Anxious/Depression, Withdrawn, Somatic Complaints, Attention Problems, and Internalizing Problems scales than refugee adolescents. In this study, no significant difference was found between the two groups on Social Problems, Thought Problems, Delinquent Behavior, Aggressive Behavior, and Externalizing scales .

Conclusion: Findings revealed that although asylum is not an ideal condition for children's and adolescents' psychological development and prosperity, it can have a protective role in comparison with war zone's circumstances. Further investigation is needed, however, to elucidate the lack of significant differences in externalizing scales among war zone and refugee adolescents.

Keywords: *Adolescent, Afghanistan, Mental health, Refugees, War*

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Children and adolescents are real victims of wars; they experience war-zones' endless stressors and endure a lifetime of suffering as a consequence. War-zones' overwhelming amount of stress can lead to behavioral and emotional problems in children and adolescents (1). These stress-induced psychological problems have been revealed in both longitudinal (2, 3) and cross sectional (4-6) studies. Crick and Gallagher (7) defined children and adolescents' "Behavioral disorders" as sever abnormal behaviors which are inappropriate of individual's age. Achenbach and Edelbrock (8) divided child and adolescent behavioral and emotional problems to eight cluster of withdrawn behavior, anxiety/depression, somatic complaints, social problems, attention problems, thought problems, delinquent behaviors and aggressive behaviors. Normal and abnormal behaviors of children and adolescents can be better explained by two general concepts of externalizing and internalizing behaviors. Externalizing syndrome includes two syndromes of delinquent and aggressive behaviors; internalizing syndrome consists of withdrawn behaviors (anxiety/depression) and somatic complaints. Different studies investigating the relationship between stress, externalizing (9-11) and internalizing syndromes (6, 9) have confirmed significant positive correlations in children and adolescents. Pathological stresses can lead to behavioral and emotional problems such as anxiety and depressive disorders, dissociative states, somatic complaints, sleep problems, nightmares, difficulties in concentration, impulse control problems, social regression and Attention Deficit Hyperactivity Disorder (ADHD) in adolescents (12-14).

At least three models have been proposed to explain the relationship between stress and psychopathology. The stress exposure model assumes that those who experience severe stressors may develop more psychological problems than others (4-6) . The prospective studies' findings of increase in pathological symptoms after stressful life events provide evidence for this model. Stressful life events were able to predict proliferation of depressive symptoms six (6) and nine (3) months later. Mathijcsen, Koot and Vehulst (15) studied a sample of Dutch adolescents referred to mental health clinics. They found that in the following year externalizing behaviors and all problems in Achenbach's child behavior checklist, except for internalizing behavior, increased with stressors. Studies in stress exposure model framework have confirmed the positive relationship between stress and adolescents' behavioral and emotional disorders.

The stress generation model (16)suggests that individuals with different psychological problems especially depression have tendencies toward generation of stressor factors concluding that stressful events dependend on their behaviors. Leadbeater et al (17) examined the predictability of stressful life events in adolescents with externalizing and internalizing syndromes. They found that externalizing and

internalizing syndromes in girls, but not boys, were able to predict stressful life events in the next year. Aseltin et al (9), in another study found that delinquent behaviors can predict high stress levels and family problems in both men and women.

The reciprocal model, the third view, argues that there is a reciprocal relationship between psychological problems and stress; stressors may lead to psychopathology and psychological problems and can predict more stressful life events (18). In Kim et al's study (19) on the relationship of stress and externalizing and internalizing syndromes, they provided some evidence for this model. They found that stress was an antecedent of externalizing and internalizing syndromes and these syndromes predicted more stressful events.

War stress, as mentioned above, has a significant correlation with behavioral and emotional problems in both children and adolescents. However, the prevalence and severity of stressors in war-zones is to be studied. The importance and breadth of war stress consequences have led to enormous studies in the recent decades. War-zone traumatic stress, as conceptualized by (1), has several components including war-related Post Traumatic Stress Disorder (PTSD). Most victims of war-zone traumatic stress are women and children.

War influences children and adolescents' well being, resulting in a pattern of bio-psychosocial syndromes (1, 20-23). Studies showed that PTSD is a prevalent condition among war-zone adolescents (24-26) and adolescent refugees (27-29) . This prevalent syndrome has a significant relationship with ADHD, anxiety disorders, brief psychotic disorders, suicidal ideation and mood disorders (30-33) . Another research reported 1.7 times more problematic behaviors including aggressiveness among children and adolescents who have experienced war 34). Lewis (35) argues that violent experiences such as war provide a model for violent behaviors and precede violent delinquent behaviors in both adolescents and adults.

War-zone stress can have a heterogeneous effect on individuals based on its interaction with other factors such as gender. Gender can influence the nature and severity of behavioral and emotional war related problems. Girls are much more likely to demonstrate mood disorders (36) and somatoform disorders (37) ;and PTSD is two times more in girls than boys (38). ADHD and Conduct disorder, on the other hand, is significantly more in boys (39). The frequency of exposure to war-zones' stressful events is another important factor (40). Seeking refuge or residing in safe places can decrease these pathogenic exposures. Thabet and Vostanis (41) , in a longitudinal study on PTSD and psychological problems of war-zone children and adolescents, found that one year separation from war-zone conditions can significantly reduce pathological symptoms. Wein et al (42) reported a similar result in Bosnian adolescent refugees.

Although asylum condition has its own stressful consequences comparing to extreme threats of war, it could be a protective factor. Although this condition can not provide ideal aspects of a normal life, it can protect children from exposure to calamity of wars. The present study compared prevalent behavioral and emotional problems among Afghan adolescent refugees and Afghan war adolescents.

Materials and Method

Participants

One hundred and eighty high school students in Herat participated in this study. The refugee group included ninety students who have spent war time in Iran. These students were chosen with two criteria; either leaving Iran in less than a year or not having any experiences of war. War-zone adolescents were chosen from the same classes with the following two criteria, either living in Herat and in its suburbs their whole lives; or experiencing war. There were 45 girls and 45 boys in each group.

Instruments

Behavioral and emotional problems of participants were measured by the "Youth Self Report" scale (YSR) based on "Achenbach System of Empirically Based Assessment" (ASEBA). This scale is applicable to adolescents from 11 to 18 years of age and is answered by adolescents themselves. Respondents first answered several questions about their strengths, weaknesses and illnesses. Then their emotional, behavioral and social problems were assessed with 113 self evaluating items. Adolescents explored their last 6 months experiences and rated the appropriateness of items with their experiences on a scale of 0 (completely false) to 2 (completely true .(

The YSR version of ASEBA included eight scales: withdrawal, anxiety/depression, somatic complaints, social problems, attention problems, delinquent behaviors and aggressive behaviors. These scales can be divided in to two general dimensions of externalizing and internalizing problems .

This project used the Persian form of YSR which has been adjusted and normed for Iranian adolescents (43). These scales had not been normed for Afghan adolescents ;and some common Persian terms were different in Afghan dialect. Hence, equivalent terms were first selected and the resulted form was then tested in a sample of 35 Afghan students in Herat. The results were examined for possible ambiguous items and then for internal consistency. All items were comprehensible; and Cronbach alpha varied in a range of 0.7 to 0.94.

Results

Descriptive analyses of data are shown in table 1. As indicated in table 1, refugee adolescents had significantly less average scores in all scales of

behavioral and emotional problems except for aggressive behavior.

Considering different numbers of items in different scales of YSR that could affect averages, we used decile scores to compare behavioral and emotional problems among refugee and war-zone adolescents. In each scale, scores below the third decile were classified as normal; scores between the third and seventh decile were assumed as borderline; and scores above seventh decile were considered as abnormal. Comparison of behavioral and emotional problems of refugee and war-zone adolescents is shown in table 2.

As it can be observed in table 2, the most important difference between refugee and war-zone adolescents was related to somatic complaints. 11.5% of the suffering from this problem. Considering gender, 14% refugee adolescents reported somatic complaints whereas 42.2% of the war-zone adolescents were of the refugee boys and 9.1% of the refugee girls reported abnormally high levels of somatic complaints comparing with 36.6% of the war-zone boys and the 46.3% of war-zone girls.

In the next step, behavioral and emotional problems of the two groups were compared with independent t test ; and the results are shown in table 3. Independent t test revealed that war-zone adolescents had significantly higher levels of anxiety/depression $t(171)=-2.54$, $p<0.05$; withdrawal $t(171)=-3.16$, $p<0.005$; somatic complaints $t(171)=-4.38$, $p<0.001$; attention problems $t(171)=-2.15$, $p<0.05$; and internalizing syndrome $t(171)=-3.89$, $p<0.001$.

War-zone male adolescents exhibited more withdrawal $t(82)=-2.03$, $p<0.05$; somatic complaints $t(82)=-3.13$, $p<0.005$; thought problems $t(74.98)=-2.60$, $p<0.05$; attention problems $t(82)=-3.32$, $p<0.001$; and internalizing syndrome $t(82)=-2.55$, $p<0.05$; than male refugees. In females, anxiety/depression $t(83)=-2.68$, $p<0.05$; withdrawal $t(83)=-2.54$, $p<0.05$; somatic complaints $t(68.75)=-3.73$, $p<0.001$; and internalizing syndrome $t(83)=-3.65$, $p<0.001$; were significantly more among war-zone adolescents.

Discussion

Wars are ubiquitous reality in humankind's history.

Table1.Means and standard deviations of refugee and war-zone adolescents on the YSR scales

Scales	Refugee Adolescents			War-Zone Adolescents		
	Male (n=43)	Female (n=44)	Total (n=90)	Male (n=41)	Female (n=41)	Total (n=83)
Anxious/ Depression	6.74(3.8)	7.59(5)	7.48(4.7)	8.12(3.9)	10.3(4.4)	9.23(4.3)
Withdrawn	4.56(2.7)	4.70(2.4)	4.70(2.5)	5.78(2.8)	6.20(2.9)	6(2.9)
Somatic Complaints	3.14(2.9)	3.34(2.3)	3.46(2.8)	5.17(3)	5.73(3.5)	5.48(3.2)
Social Problems	5.84(3.2)	5.57(3)	5.93(3.3)	6.83(3.1)	6.71(3)	6.76(3)
Thought Problems	4.23(3.4)	3.86(2.9)	4.37(3.6)	6.46(4.4)	4.54(3.4)	5.47(4)
Attention Problems	4.77(3.1)	5.57(4.3)	5.38(3.9)	6.93(2.8)	6.27(3.6)	6.55(3.2)
Delinquent Behavior	3.93(2.3)	2.61(1.9)	3.49(2.6)	4.44(3.8)	3.32(2.3)	3.93(3.2)
Aggressive Behavior	7(4.8)	7.87(4.4)	7.94(5.9)	7.76(5.1)	8.17(5.5)	7.93(5.3)
Externalizing	10.9(6.4)	10.4(5.8)	11.4(7.8)	12.2(8.4)	11.5(7.2)	11.9(7.7)
Internalizing	14.5(8.4)	15.5(7.9)	15.6(8.7)	19.1(8.1)	22.2(8.8)	20.7(8.5)

Table2. Percentage of refugee and war-zone adolescents in different ranges of vioral problems

	Refugee Adolescents									War-Zone Adolescents								
	Male			Female			Total			Male			Female			Total		
	Normal	Borderline	Abnormal	Normal	Borderline	Abnormal	Normal	Borderline	Abnormal	Normal	Borderline	Abnormal	Normal	Borderline	Abnormal	Normal	Borderline	Abnormal
Anxious/ Depression\	48.8	34.9	16.3	43.2	29.5	27.3	46	32	22	26.8	51.2	22	17.1	31.7	51.2	21.7	42.2	36
Withdrawn	41.9	46.5	11.6	38.6	50	11.4	40	48.5	11.5	29.3	36.6	34.1	14.6	48.8	36.6	21.7	43.4	34.9
Somatic Complaints	53.5	32.6	14	43.2	47.7	9.1	48.3	40.2	11.5	22	41.5	36.6	17.1	36.6	46.3	19.3	38.6	42.2
Social Problems	41.9	37.2	20.9	38.6	43.2	18.2	40.2	40.2	19.5	24.4	41.5	34.1	29.3	46.3	24.4	26.5	44.6	28.9
Thought Problems	37.2	34.9	27.9	38.6	38.6	22.7	37.9	36.8	25.3	19.5	36.6	43.9	29.3	51.2	19.5	24.1	44.6	31.3
Attention Problems	34.9	48.8	16.3	43.2	38.6	18.2	39.1	43.7	17.2	14.6	53.7	31.7	26.8	41.5	31.7	21.7	47	31.3
Delinquent Behavior	30.2	44.2	25.6	52.3	36.4	11.4	41.4	40.2	18.4	39	34.1	26.8	46.3	34.1	19.5	42.2	33.7	24.1
Aggressive Behavior	37.2	41.9	20.9	29.5	43.2	27.3	33.3	42.5	24.1	31.1	39	26.8	29.3	43.9	26.8	31.3	42.2	26.5
Externalizing	34.1	29.3	36.6	34.1	36.6	29.3	33.7	33.7	32.5	34.1	29.3	36.6	34.1	36.6	29.3	33.7	33.7	32.5
Internalizing	51.2	30.2	18.6	40.9	40.9	18.2	46	35.6	18.4	22	48.8	29.3	14.6	39	46.3	18.1	44.6	37.3

Table3. t test results of comparing refugee and war-zone adolescents.

Variable	Mean Difference	t	p
Anxious/ Depression	-1.75	-2.54	0.012
Withdrawn	-1.30	-3.16	0.002
Somatic Complaints	-2.03	-4.38	0.000
Social Problems	-0.83	1.70	0.090
Thought Problems	-1.10	-1.90	0.058
Attention Problems	-1.18	-2.15	0.032
Delinquent Behavior	-0.44	-0.99	0.322
Aggressive Behavior	-0.01	0.02	0.984
Externalizing	-0.42	-0.35	0.722
Internalizing	-5.10	-3.89	0.000

They are reminiscent of desperation and bereavement of their numberless victims. Wars' consequences are so deep and extensive that they do not alleviate with years. Stress is one of the most prevalent psychological results of wars. Although wars' stress is widespread, its influence on children is of utmost importance. Several studies confirm that huge stresses of war-zones may result in children's and adolescents' behavioral and emotional problems (20-23, 30-34).

The current project tried to evaluate behavioral and emotional problems of Afghan adolescents who have suffered from war consequences their whole lives. This was done with the comparison of behavioral and emotional problems of war-zone adolescents and refugee adolescents. Findings indicated that adolescents who had experienced war stressors and traumas had significantly more behavioral and emotional problems than those who had been far from direct affects of war.

War-zone adolescents exhibited more anxiety/depression, withdrawal, somatic complaints, attention problems and internalizing syndrome than refugee adolescents. These findings emphasized the protecting role of asylum conditions against wars' stresses and their psychological consequences (40-42). The stress exposure model (4-6) suggests that war-zone adolescents' exposure to stressful events can explain the obtained results. The stress generation model (16) and reciprocal model (18), on the other hand, predict that war-zone adolescents would have more stressful events in the future.

This study did not find any significant differences between war-zone and refugee adolescents in social problems, thought problems, delinquent behaviors, aggressive behaviors and externalizing syndrome. Further investigations revealed that war-zone girls showed significantly more depression than refugee girls, whereas war-zone boys showed significantly more attention problems. These gender based diversities are in agreement with known differences in girls' and boys' psychopathology. There is a longstanding consensus that girls are more vulnerable to depression (36) and boys are more vulnerable to attention problems (39).

Although cross sectional research limitations do not permit us to suggest any certain explanation for lack of significant differences between refugee and war-zone adolescents in social problems, thought problems, delinquent behaviors, aggressive behaviors and externalizing syndrome, researcher speculations may be of worth for further investigations. It is possible that Afghan adolescents are normal with respect to the mentioned scales and that war or asylum circumstances have no influence on these areas of behavior. However, it is more likely that both war-zone and refugee adolescents have more troubles in these areas than normal adolescents ,implying that asylum condition is not able to protect adolescents from externalizing problems or from exacerbating them. More investigation is needed to elucidate findings related to externalizing problems.

It should be noted that participants of this study were among those lucky students who had the chance of attending high school. There are lots of Afghan children and adolescents who are still deprived of education despite the termination of the war.

References

1. Parson ER. Understanding Children with War-Zone Traumatic Stress Exposed to the World's Violent Environments. Journal of Contemporary Psychotherapy 2000; 30: 325-340.
2. Compas BE. Stress and life events during childhood and adolescence. Clin Psychol Rev 1987; 7: 275-302.
3. Compas BE, Connor-Smith JK, Saltzman H, Thomsen AH,Wadsworth ME. Coping with stress during childhood and adolescence: problems, progress, and potential in theory and research. Psychol Bull 2001; 127: 87-127.
4. Hammen C,Goodman-Brown T. Self-schemas and vulnerability to specific life stress in children at risk for depression. Cognit Ther Res 1990; 14: 215-227.
5. Hilsman R,Garber J. A test of the cognitive diathesis-stress model of depression in children: academic stressors, attributional style, perceived competence, and control. J Pers Soc Psychol 1995; 69: 370-380.
6. Rudolph KD, Lambert SF, Clark AG,Kurlakowsky KD. Negotiating the transition to middle school: the role of self-regulatory processes. Child Dev 2001; 72: 929-946.
7. Mc Culloch A, Wiggins RD, Joshi HE,Sachdev D. Internalizing and Externalizing children's Behavior Problems in Britain and the US: Relationship to Family Resources. Children and society 2000; 14: 368-383.
8. Achenbach TM, Edelbrock C. Manual for the Youth Self-Report and Profile. Burlington, VT: University of Vermont, Department of Psychiatry, 1987
9. Aseltine RH, Jr., Gore S,Gordon J. Life stress, anger and anxiety, and delinquency: an empirical test of general strain theory. J Health Soc Behav 2000; 41: 256-275.
10. Barrett S,Heubeck BG. Relationships between school hassles and uplifts and anxiety and conduct problems in grades 3 and 4. J Appl Dev Psychol 2000; 21: 537-554.

11. Jackson Y,Warren JS. Appraisal, social support, and life events: predicting outcome behavior in school-age children. Child Dev 2000; 71: 1441-1457.
12. Green AH. Physical abuse of children. In: Weiner J, eds. American Academy of Child and Adolescent Psychiatry textbook of child and adolescent psychiatry . Washington, DC: American Psychological Association; 1997.
13. Mollica RF, Poole C, Son L, Murray CC,Tor S. Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status. J Am Acad Child Adolesc Psychiatry 1997; 36: 1098-1106.
14. Thabet AA, Abed Y,Vostanis P. Comorbidity of PTSD and depression among refugee children during war conflict. J Child Psychol Psychiatry 2004; 45: 533-542.
15. Mathijssen JJ, Koot HM,Verhulst FC. Predicting change in problem behavior from child and family characteristics and stress in referred children and adolescents. Dev Psychopathol 1999; 11: 305-320.
16. Hammen C. Generation of stress in the course of unipolar depression. J Abnorm Psychol 1991; 100: 555-561.
17. Leadbeater BJ, Kuperminc GP, Blatt SJ,Hertzog C. A multivariate model of gender differences in adolescents' internalizing and externalizing problems. Dev Psychol 1999; 35: 1268-1282.
18. Cohen LH, Burt CE,Bjorck JP. Life stress and adjustment: Effects of life events experienced by young adolescents and their parents. Dev Psychol 1987; 23: 583-592.
19. Kim HK, Capaldi DM,Stoolmiller M. Depressive symptoms across adolescence and young adulthood in men: Predictions from parental and contextual risk factors. Dev Psychopathol 2003; 15: 469-495.
20. Dyregrov A,Raundalen M. Children and war: A review of the literature. In: Dodge C,Raundalen M, eds. War, violence, and children in Uganda. Oslo: University of Oslo Press; 1987.
21. Gaensbauer T, Chatoor I, Drell M, Siegel D,Zeanah CH. Traumatic loss in a one-year-old girl. J Am Acad Child Adolesc Psychiatry 1995; 34: 520-528.
22. Kuterovac G, Dyregrov A,Stuvland R. Children in war: a silent majority under stress. Br J Med Psychol 1994; 67: 363-375.
23. Slaby R, Stringham P. Prevention of peer and community violence: The pediatrician's role. Am Acad Pediatrics 1994; 94:603–616.
24. Dyregrov A, Gupta L, Gjestad R,Mukanoheli E. Trauma exposure and psychological reactions to genocide among Rwandan children. J Trauma Stress 2000; 13: 3-21.
25. Qouta S, Punamٍki RL,Sarraj EE. Prevalence and determinants of PTSD among Palestinian children exposed to military violence. Eur Child Adolesc Psychiatry 2003; 12: 265-272.
26. Stein B, Comer D, Gardner W,Kelleher K. Prospective study of displaced children's symptoms in wartime Bosnia. Soc Psychiatry Psychiatr Epidemiol 1999; 34: 464-469.
27. Almqvist K,Brandell-Forsberg M. Refugee children in Sweden: Post-traumatic stress disorder in Iranian preschool children exposed to organized violence. Child Abuse Negl 1997; 21: 351-366.
28. Awadh AM, Vance B, El-Beblawi V,Pumariega AJ. Effects of trauma of the Gulf war on Kuwaiti children. J Child Fam Stud 1998; 7: 493-498.
29. McCloskey LA,Southwick K. Psychosocial problems in refugee children exposed to war. Pediatrics 1996; 97: 394-397.
30. Cuffe SP, McCullough EL,Pumariega AJ. Comorbidity of attention deficit hyperactivity disorder and post-traumatic stress disorder. J Child Fam Stud 1994; 3: 327-336.
31. Famularo R, Fenton T, Kinscherff R,Augustyn M. Psychiatric comorbidity in childhood post traumatic stress disorder. Child Abuse Negl 1996; 20: 953-961.
32. Yule W. Post-traumatic stress disorder in child survivors of shipping disasters: the sinking of the Jupiter'. Psychother Psychosom 1992; 57: 200-205.
33. Yule W. Post-traumatic stress disorder. Arch Dis Child 1999; 80: 107-109.
34. Chimienti G, Nasr JA,Khalifeh I. Children's reactions to war-related stress. Soc Psychiatry Psychiatr Epidemiol 1989; 24: 282-287.
35. Lewis DO. From abuse to violence: Psychophysiological consequences of maltreatment. J Am Acad Child Adolesc Psychiatry 1992; 31: 383-391.
36. Derluyn I,Broekaert E. Different perspectives on emotional and behavioural problems in unaccompanied refugee children and adolescents. Ethn Health 2007; 12: 141-162.
37. Kaplan J,Sadock A. Synopsis of Psychiatry. (9 th ed). Philadelphia: Lippincott Williams and Wilkins; 2003.
38. Polin DF,Breslau N. Sex differences in risk of PTSD. PTSD research Quarterly 2007;18.
39. Szatmari P, Offord DR,Boyle MH. Ontario Child Health Study: prevalence of attention deficit disorder with hyperactivity. J Child Psychol Psychiatry 1989; 30: 219-223.
40. Joshi PT,O'Donnell DA. Consequences of child exposure to war and terrorism. Clin Child Fam Psychol Rev 2003; 6: 275-292.
41. Thabet AA,Vostanis P. Post traumatic stress disorder reactions in children of war: a longitudinal study. Child Abuse Negl 2000; 24: 291-298.
42. Weine SM, Vojvoda D, Becker DF, McGlashan TH, Hodzic E, Laub D, et al. PTSD symptoms in Bosnian refugees 1 year after resettlement in the United States. Am J Psychiatry 1998; 155: 562-564.
43. Minaee A. Adaptation and standardization of Child Behavior Checklist, Youth Self-Report, and Teacher's Report Forms. Research on Exceptional Children 2006; 19: 529-558.