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ABSTRACT

The phenomenon of adolescent runaway behavior is of critical concern to mental health professionals. Conceptualization, prediction, and treatment interventions are of extreme importance. This study sought to build upon prior research by using the Personality Inventory for Children (PIC). Previous research indicated that adolescent running away could be predicted with great accuracy. The current study extended the prior research by using a profile classification system (typology) as well as actuarial interpretive guidelines both associated with the PIC. The results indicated that the PIC classification system identified 93.4% of the runaway sample. In addition, this classification system had corresponding DSM-III tentative diagnoses associated with it. It was recommended that a more fruitful approach to conceptualizing the adolescent runaway and his/her family was to view it as emotional disturbance within the context of a dysfunctional family. It was further recommended that runaway programs use the PIC as a screening measure which would be useful for initial assessments, treatment interventions, and for referral purposes to other professionals when the adolescent and family left the runaway program. (Contains 54 references. Two figures and three tables present data and statistical analysis.) (Author/TS)

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A descriptive study of the behavior and personality characteristics of adolescent runaways using the Personality Inventory for Children

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Abstract

The phenomenon of adolescent runaway behavior is of critical concern to mental health professionals. Estimates of incidents range from two million up to four million per year. Conceptualization, prediction, and treatment interventions are of extreme importance. This study sought to build upon prior research by this author using the Personality Invetory for Children (PIC). Previous research indicated that adolescent running away could be predicted with great accuracy. The current study extended the prior research by using a profile classification system(typology) as well as actuarial interpretive guidelines both associated with the PIC. The results indicated that the PIC classification system identified 93.4% of the runaway sample. In addition, this classification system had corresponding DSM-III tentative diagnoses associated with it. Besides Conduct Disordered diagnoses, other tentative diagnoses such as Major Depression, Dysthymia, Organic Brain Syndrome, Pervasive Developmental Disorder, Developmental Disorders, and Attention Deficit Hyperactivity Disorder were assigned to the subjects' profiles. The actuarial interpretive guidelines provided descriptors that highly overlapped with the descriptors reported in the reviewed literature

on adolescent runaway behavior. It was recommended that a more fruitfull approach to conceptualizing the adolescent runaway and his/her family was to view it as emotional disturbance within the context of a dysfunctional family. It was further recommended that runaway programs use the PIC as a screening measure which would be useful for initial assessments, treatment interventions, and for referral purposes to other professionals when the adolescent and family left the runaway program.

Nationally, estimates indicated that the number of adolescents that ran away from home each year ranged from 1 million (Walker, 1975) to 2 million (Freudenberger & Torkelson, 1984) with predictions as high as 4 million (National Network of Runaway and Youth Services (NNRYS), 1985). The NNRYS (1991) had recently reported that the current mean estimate of runaways per year was 2 million. Pragmatically, 3 percent of American families have an adolescent run away from their home each year (Garbarino, 1986) and approximately 1 out of 9 secondary students may have a runaway history (Rohr & James, 1994). Prior reviews of the literature on runaway behavior have focused on the relationship between the runaway and their family. A current review indicated that there were additional problematic areas and behaviors that were of focus. Conceptually, there were parental problems, delinquent behavior, academic problems, peer relationship difficulties, and problems symptomatic of psychopathology (Rohr, 1991).

Problematic Areas

The problematic area of Family Relationships consisted of behaviors such as parental rejection (Adler, 1980), constant downgrading of the child (Spillane - Grieco, 1984), separation and divorce (Ackerman, 1980), intolerable and conflictual home conditions (Blood & D'Angelo, 1974), sibling rivelry problems (Johnson & Peck, 1978), problems communicating with members of their family (Gullata, 1979), the family members not expressing their love for each other (Blood & D'Angelo, 1974), and mutual lack of care and love for each other (Spillane - Greico, 1984). The Parental Problems area included behaviors such as the parents using excessive punishment (Brandon, 1975), parents having a history of drug usage (Steinbock, 1978), and being inadequate in managing their childrens' behavior (Bell, 1984; Wodarski & Ammons, 1981). Behaviors such as stealing (Edelbrock, 1980), disobedience (Blood & D'Angelo, 1974), legal difficulties (Schmidt, 1975), truancy (Nye, 1980), and being adjudicated a delinquent (Linden, 1979) comprised the Delinquent Behavior area. The School

Problem area included behaviors such as having a negative attitude toward school (Nye, 1980), poor problem - solving skills (Roberts, 1982a), and school behavior problems (Gutierres & Reich, 1981). Poor social relationships (Gilchrist, 1984) comprised the Peer Relationships area. Finally, Symptoms of Psychopathology included behaviors such as anxiety (Williams, 1977), suicidal tendencies (Norey & Donohue, 1985), having been physically abused (Harris, 1980), sexually abused (Hughes, 1981), and having used alcohol and drugs (Maar, 1984).

These earlier findings have been supported by more recent research. The NNRYS (1985) surveyed approximately 51,000 youth in 210 runaway facilities and found that some of the main presenting problems were depression, suicidal tendencies, alcohol and drug usage, physical abuse, sexual abuse, and the generic category - severe psychological problems. The most recent survey by the NNRYS (1991) essentially replicated some of their 1985 findings. 50,000 youth in 146 runaway facilities were surveyed. The results indicated that 46 percent of the youth had a substance

abuse problem with 14 percent being addicted. Thirty-one percent reported suffering physical abuse and 21 percent reported having been sexually abused. Sixty-one percent reported being depressed with 21 percent having had suicidal ideations.

Review of Representative Instruments

The literature indicated that while the general focus has been on assessing the personality characteristics of runaways, very few normed personality instruments had been used to do this. Those instruments that were used had serious psychometric limitations. A listing and brief summary of the Mental Measurements Yearbook critiques of the instruments used to assess the problematic areas follows.

In studying the area of Family Relationships, Steinbock (1977) used the Family Enviornment Scale, the Family Life Space Diagram, and the Family Life Questionaire. Maar (1984) used the Index of Family Relation Scale, the Child's Attitude Toward Mother Scale, and the Child's Attitude Toward Father Scale. In assessing Parental Problems, Adler (1980) developed the Runaway Prone Questionaire. Van-Houten (1977) developed

the Life Events Inventory. To investigate Delinquent Behavior, Linden (1979) used the Jesness Inventory. Adler (1980) and Van-Houten (1977) investigated the problematic area of School Problems and used the self-developed instruments mentioned above. The area of Peer Relationships was also assessed by Adler (1980) using the Runaway Prone Questionairre. The problematic area of Symptoms of Psychopathoplogy was investigated by Burke (1985), who used the Millon Adolescent Personality Inventory and Phillip's (1976) who used the High School Personality Questionaire and the Rutgers Self Descriptive Questionaire - Parts I and II.

Of the twelve tests cited, professional reviews were found in the Mental Measurements Yearbooks (MMY) (Buros, 1972; 1978; 1985) only for the Family Environment Scale, the Jesness Inventory, the Millon Adolescent Personality Inventory, and the High School Personality Questionaire. The reviewers concluded that the reliability of the Family Environment Scale was relatively acceptable but no validity studies had been provided. The Jesness Inventory had reliability data for males but none for females. There was no

validational data provided for the scales of the Jesness Inventory. The reliability of the Millon Adolescent Personality Inventory (MAPI) was reltively acceptable, but there was very little empirical support for 16 of the 20 subscales. Validational data was lacking for the MAPI. The reliability of the High School Personality Questionairre was modest and validational data was lacking.

In summary, the reviewers' conclusions raised several concerns. One was that the psychometric limitations of the instruments used may qualify some of the prior research findings on adolescent runaways. A second concern was the issue of parsimoniousness. No one test reflected the range and degree of behaviors and personality characteristics associated with the adolescent runaway. With a high incidence population that may be emotionally disturbed and highly problematic, a more recent and valid assessment of the adolescent runaways' behavior and personality seemed appropriate. The assessment instrument used should be a normed personality measure, with few psychometric limitations, that has norms for both genders, and whose

clinical scales were reflective of the behaviors and personality characteristics beleived to be associated with adolescent runaways.

The purpose of this study was to investigate the empirical and clinical utility of the Personality Inventory for Children (PIC) in describing the personality and behaviors of adolescent runaways.

Method

Instrument

The PIC is a 600 item, parent informant, multidimentional measure of child and adolescent behavior, affect cognitive ability, psychopathology, and family functioning. The original scales were constructed using either an empirical or rational/content scale construction strategy. The scales were normed on a sample of 2582 normal children (no previous mental health contact; 192 subjects ages 3 to 5; 2390 subjects ages 6 to 16). Norms were established for each gender, ages 3 to 5 and 6 to 16. The standard PIC profile included 3 scales that measured informant response set, Lie (L), Frequency (F), and Defensiveness (DEF); a general screening

scale, Adjustment (ADJ); and 3 scales which reflected intellectual and academic functioning, Achievement (ACH), Intellectual Screening (IS), and Development (DVL; and 9 clinical scales, Delinquency (DLQ), Hyperactivity (HPR), Somatic Concern (SOM), Depression (D), Withdrawal (WDL), Anxiety (ANX), severe psychopathology, Psychosis (PSY), social skills functioning, Social Skills (SSK), and family conflict and parental emotional instability, Family Relations (FAM). Scale scores were reported in T score units (M = 50, SD = 10); high scores indicated pathological adjustment. Factor-derived broad-band and shortened profile scales were also available (Lachar, 1982; Lachar, Gdowski, & Snyder, 1982).

Lachar's (1982) shortened version of 280 items was used in this study. Estimates of internal consistancy indicated that between the original and shortened forms there was no significant change. Test-retest reliability indicated that the shortened version retained the temporal stability of its full-length counterpart. Correlations between the shortened and full-length versions of the PIC ranged from .88 to .89

(Forbes, 1986). The percentage of clinical interpretive agreement between the original and shortened version scales was from 92% to 97% (Lachar, 1982).

The PIC was chosen for numerous reasons. First, the scales of the PIC seemed reflective of the behaviors and characteristics associated with runaways as reviewed above and elsewhere (Rohr, 1991). Second, the use of a parent informant test had several advantages. Typically, parents have been able to generate a more comprehensive descriptiopn of their child's behavior than other observers (teachers, clinicians)(Achenbach, 1978). Third, the PIC was not limited to children/adolescents who had relatively mature conceptual skills, adequate reading ability, and motivation (Lachar, 1984). Fourth, the PIC was aptly suited to an assessment that was family and systemically oriented. Finally, it had actuarial interpretive guidelines (Lachar and Gdowski, 1979) and a profile classification system (Gdowski, Lachar, and Kline, 1985) that provided much clinical information

and tentative DSM-III diagnoses. This information can be extremely useful for treatment planning and referral purposes.

Validity and Reliability

The MMY (1985; 1989) critiques indicated that citing the numerous validity analyses conducted was inappropriate. A concluding summary statement of the PIC's validity studies indicated that the validity was excellent. Three test-retest reliability studies were cited. For a psychiatric outpatient sample, the mean reliability coefficient was .86; for a normal sample the mean was .71; and for a different sample of normal children, the mean was .89. Internal consistancy estimates had mean alpha of .74. Mother - father interrater reliabilities had a mean of .57 for a sample of normal children; a mean of .64 with a clinical sample; and a mean of .66 for a psychiatric outpatient sample.

Subjects and Data Collection

The target group was all of the runaway residents who resided at the Family Link/Runaway House in Memphis, Tennesse between 1986 and 1988, whose

custodians/gaurdians (primarily females) completed the PIC prior to their first therapy session. Of the 250 eligable subjects during this period, 63 gaurdians consented to participate. Two subjects' protocols were invalid, reducing the sample size to 61. The age range was 13 to 17, with a mean age of 15.0 years. Thirty-five (57.3%) were first time runaways and twenty-six (42.7%) had run away from home more than once.

This naturalistic sample presented with numerous emotional and psychological problems. Assessment findings and clinical interviews conducted by licensed and certified Master's degree level clinicians indicated that 73% met DSM-III or DSM-III-R criteria for either Dysthymia or Major Depression with 59% having attempted suicide or had suicidal ideations. Nineteen percent had alledged physical abuse. Eighteen percent had alledged sexual abuse. Twenty-nine percent had prior mental health treatment of which 16% had prior psychiatric hospitalization. These findings are similar to the survey findings of the NNRYS (1985; 1991) as mentioned above.

Additional demographic similarities existed between this sample and national demographic estimates on runaways. Table 1 illustrates the comparison of the target sample to other samples (Family and Youth Services Bureau(FYSB), 1989; General Accounting Office(GAO), 1989; NNRYS, 1991). Racial identity and age were the two demographics that were the most similar among the groups. Gender characteristics were the most dissimilar.

{ PLACE TABLE 1 ABOUT HERE }

Program description

A runaway program is typically a state licenced, 24-hour-a- day, crisis-oriented, residential treatment facility for adolescents, ages 13-17, who have run away from home. Runaway programs offer a vast array of services including individual, group, and family counseling; educational and vocational services; leisure and recreational activities; alcohol and drug counseling; health care; and information, referral, and outreach services.

The general treatment approach of runaway programs is family and systems oriented, focusing on identifying problems, deescalating the crisis, establishing communication among family members, and attempting to effect enough systemic change so that the home environment can be stabilized. Aftercare and follow-up services are also provided by the runaway program.

Procedure

PIC Profile Typology

Gdowski, Lachar, and Kline (1985) used cluster analysis (a statistical algorithm that uses profile data to form groups) and identified a total of 11 PIC profile types that replicated across two independent samples of almost 900 children and adolescents, each refered for mental health services. These PIC profile types differred significantly across several behavior checklists completed by parents, classroom teachers, and interviewing child clinicians. In addition, the PIC profile groups also differed with regard to child age and sex, but not race or socioeconomic status. Kline, Lachar, and Gdowski (1987) constructed classification rules for this typology to be used with the PIC

profiles of individual children/ adolescents. These rules classified over 90% of all cases. Also, a classification rule was developed that identified a twelth PIC profile type: Those profiles that featured a single PIC scale in the clinically elevated range (or "spike" profiles).

The 12 PIC profile types included one group that attained within-normal-limits profiles (WNL; Type 1), described by parents, teachers, and clinicians as exhibiting significantly better adjustment than children who attained other PIC profile types; the afore mentioned "spike" profile group, with only one PIC scale elevation in the clinical range (Type 2); four profile groups that had significant elevations on PIC scales which measure child cognitive and academic functioning (Type 3,4,5,6), and rated by all informant sources as exhibiting intellectual deficits; and six profile groups (Types 7,8,9,10,11,12) that exhibited various patterns of emotional and/or behavioral problems. This classification system yeilds an average of 40 replicated behavior correlates per profile type,

as reported by teacher, parents, and clinicians. Corresponding tentative DSM-III diagnoses were also provided.

Actuarial Interpretation

Additional interpretive strateges are used for those protocols that only have a single scale elevation, TYPE 2 "spike" profiles. Lachar and Gdowski (1979) have developed an actuarial system designed to render interpretive hypotheses or rather assign behavioral correlates to PIC T scores. Differing behavioral correlates are associated with ranges of scores. For instance, with the ADJ scale the same interpretation is given to any scale score 60T and above. Whereas, with the DLQ scale differing interpretations are given to scale scores between 80-89T, 90-99T, greater than 99T and greater than 109T.

Classification

To classify an individual youth's PIC profile, one follows the chart (Figure 1) down until one finds the first PIC T score requirements that the profile satisfies, and the profile is classified as that type.

{ PLACE FIGURE 1 ABOUT HERE }

Rule 1 identifies all within-normal-limits (WNL) profiles, with scores on all 12 clinical scales in the normal range (T < 60 for ACH, DVL, FAM, and HPR; T < 70 for IS, SOM, D, WDL, ANX, and SSK; T < 80 for DLQ and PSY; Lachar & Gdowski, 1979a). Rule 2 identifies all profiles that have a single significantly elevated PIC scale and, thus, classifies a total of 12 "spike" types of profiles. The next decision point in the flow chart is whether the T score for IS (Intellectual Screening) is > 69T, which suggests cognitive dysfunction. Rules 3 through 6 classify "cognitive deficit" profile types, which have elevated scores on IS and at least one of the other PIC scales that reflect cognitive functioning (ACH or DVL). Rules 7 through 12 classify "noncognitive deficit" profiles, which have normal-range (T < 70) IS scores, but have elevations on scales that suggest conduct or emotional problems. An individual youth's PIC profile can be unclassified at two points in this decision tree, and these are indicated by the "exit" points in Figure 1.

Results

Gender Differences

The ratio of females(49) to males(12) in this naturalistic sample was discrepant (4:1). An ANOVA was performed on the PIC scales ADJ through SSK to determine if the male and female subjects were significantly different from each other. There were significant differences only on 2 scales: ADJ (1,59) $F = 8.12$, $p < .01$; and IS (1,59) $F = 12.35$, $p < .01$. There were no significant differences ($p > .01$) between males and females on the scales ACH, SOM, DVL, D, FAM, DLQ, WDL, ANX, PSY, HPR, and SSK. The significant differences between the gender groups were on the two PIC scales, ADJ and IS (see Table 2).

{ PLACE TABLE 2 ABOUT HERE }

However, these statistical differences on the ADJ and IS scales did not manifest in a significant clinical/interpretive sense, when either the PIC actuarial interpretive guidelines were used or when the classification system was applied.

The mean scale scores were: ADJ, female 86T and male 98T; IS, female 49T and male 69T. The above mentioned actuarial interpretive system was applied to these individual PIC scale T scores. For both gender groups, any score 60T or above on the ADJ scale receives the same interpretation. On the IS scale, an interpretation is not provided unless the scale score is 70T or above. Since neither gender group achieved the minimum cutoff score of 70T, therefore no interpretation was provided. Thus, a clinical/interpretive distinction was not made between the two groups.

The PIC classification system (Figure 1) was applied to the mean PIC scale profile of the male and female groups (see Table 2). The male group was classified TYPE 10. The female group was also classified TYPE 10. The gender groups were then combined. The classification system was applied to the mean PIC scale profile of the total runaway group. The target group, as a whole, was classified TYPE 10.

Classification and description

To investigate the clinical utility of the PIC in describing the behavior and personality characteristics of runaways, the classification system was applied individually to each of the 61 runaway protocols. Table 3 provides a breakdown of the protocols into the specific PIC Profile TYPES, frequency, and the corresponding DSM-III diagnoses.

{ PLACE TABLE 3 ABOUT HERE }

Fifty-seven or 93.4% of the protocols were able to be classified. None of the subjects personality profiles were a TYPE 1 (Within-Normal-Limits). None of the profiles had only one scale elevated, TYPE 2 ("spike"). Four (6.3%) were not classifiable (EXIT). Twenty-six (42.6%) were a profile TYPE 10. This modal profile indicates that a large proportion of these runaways exhibited behaviors that may meet the criteria for a dignosis of Conduct Disorder - Undersocialized Aggressive, Attention Deficit Hyperactivity Disorder or Adjustment Disorder with Disturbance of Emotions. The interpretation that is associated with a Type 10 profile is presented in Figure 2. The other profile

TYPES (3,4,5,7,8,9,11), while indicating that behavioral/conduct problems predominate, also indicate the possible presence of other severe psychological problems. Some runaways may exhibit behaviors that meet the criteria for a diagnosis of Major Depression or Dysthymia, Organic Brain Syndrome, Pervasive Developmental Disorder,or a Developmental Disorder.

{PLACE FIGURE 2 ABOUT HERE}

Discussion

The purpose of this study was to (a) use a psychometrically sound personality measure (PIC), (b) that would adequately describe the behavior and personality characteristics of adolescent runaways, and (c) to determine if it was clinically useful. Other instuments that had been previously used in assessing the behavior and personality of adolescent runaways had psychometric limitations. The MMY critiques of the PIC indicated that it is a valid and reliable measure of adolescent behavior, personality, psychopathology, and family dysfunction.

The development of the actuarial interpretive guidelines and the profile classification system greatly enhances the PICs' applicability with runaways. The classification system provided a wealth of clinical information regarding education, personality, psychopathology, family, and parental functioning. These clinical descriptors greatly overlapped with the reviewed research which is italisized in Figure 2. This commonality suggests that the PICs' scales reflect the range and degree of behaviors, personality characteristics, and family dysfunction associated with the adolescent runaway.

In addition to the clinical utility of the PIC, conceptual benifits are also present. The research on adolescent runaways is inconsistant. The research effort is not concerted and there is not a theoretical underpinning to guide the investigation of this social and psychological phenommenon. The findings of this study indicate that more explanatory power is present when perceiving adolescent runaways as being possibly emotionally disturbed and their families as dysfunctional. With this premise, seemingly discrepant

data is made applicable and utilitarian regarding treatment considerations and understanding this high incidence population.

The range of the profile types and associated diagnoses indicate that runaway subjects are very similar to youth seen in various mental health settings. As noted above, twenty-six percent of the runaways had previous mental health treatment of which 16% had prior hospitalization. Prior research has indicated that runaways were overrepresented in outpatient mental health settings and that running away is a high incidence behavior among disturbed youth (Edelbrock, 1980). In fact, the runaways were more emotionally disturbed than nonrunaways as evidenced by higher ratings on the Child Behavior Checklist scales characterizing delinquency and subtypes of delinquency. Edelbrock concluded that runaways may be in need of comprehensive and perhaps long - term mental health services.

Recent research (Cahill, 1988) compared psychiatrically hospitalized runaways with hospitalized adolescents with no runaway history.

There was a significant difference (p < .01) between them. Seventeen percent of the runaways obtained a MMPI 4/8 high point code type which has clinical discriptors of anti - social behaviors in combination with schizophrenic symptomatology. Twenty-nine percent obtained a 4/9 code type which includes the classic features of the anti - social personality type. Sixteen percent of the inpatient non - runaways obtained a high point code type of 4/8 and only 11% obtained a 4/9 code type. While youth with histories of running away may be seen in various mental health settings (outpatient, inpatient) for anti-social behavior, runaways also present with additional psychological symptoms. Being viewed as emotionally disturbed and in need of psychotherapeutic counseling services would benifit more than being seen as a status-offender or delinquent.

This study's description of adolescent runaway behavior and personality is similar to other research findings on conduct disordered adolescents. The PIC classification systems' interpretation (see Figure 2) provides information on the runaways parental and

family dynamics. This interpretation is consistent with research on the family dynamics of conduct disordered youth. Herbert (1980) found that several factors characterize the families of youth with persistant conduct problems. They were: discord and quarrelling, inconsistent discipline, being too severe or lax in disciplining, divorce or separation of parents, lack of affection, parents showing excessive rejection, hostile or critical behavior toward their children, and parents with high rates of psychological problems.

The prognosis for conduct disordered diagnostic groups is usually poor with anti - social behavior being relatively stable over time; and, that they are refractory to mental health intervention (Kazdin, 1987). Kazdin (1987) futher notes that conduct problems during adolescence portend problems in adulthood. Such problems include criminal behavior, alcoholism, antisocial personality, other psychiatric problems, and poor work, marital, and occupational adjustment. These findings are similar to the findings of follow - up studies on former runaways. Earlier work, such as that of Robins (1958), found that former runaways had higher

rates of mental illness - specifically sociopathic personality. Robins and O'Neal (1959) found that former runaways had more frequent arrests and divorces than non-runaways. Later studies indicated that runaways curtailed their schooling and had trouble with the law (Olson, 1977). They also required the assistance of social service agencies for nervous and emotional problems (Olson, Liebow, Mannino, & Shore, 1980).

Conclusion

The psychopathology of the adolescent runaway has been little discussed (Adams & Monroe, 1979; Burke & Burkhead, 1989) and even less evaluated (Edelbrock, 1980; Rohr, 1991). The findings from this study strongly suggest that the behavior, personality characteristics, and family dynamics of runaways present as a cluster of behaviors remarkably similar to seriously emotionally disturbed youth. This conclusion echos Edelbrock (1980): That running away from home may be a symptom of broader syndromes of psychopathology and patterns of maladaption that are associated with delinquency.

It is recommended that those mental health professionals who work with runaways, especially those in runaway programs, seriously consider using the PIC for assessment purposes and referral recommendations for follow-up services. Findings from the NNRYS (19--) survey indicated that the runaways currently being seen at runaway programs are presenting with more serious psychological problems. It was recommended that runaway programs hire more professionally trained staff therapists to help this seriously troubled group of adolescents.

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TABLE 1

Comparison of runaway sample and national estimates on runaway demographics (age, sex, race).

Group	Runaway	GAO	FYSB	NNRYS
Age <14	36.1%	NA	42%	38%
Age 15-17	63.9%	NA	56%	54%
Male	18%	35%	43%	47%
Female	82%	65%	57%	53%
Black	36.1%	NA	NA	20%
White	63.9%	NA	NA	75%

TABLE 2

PIC mean scale T scores for runaway males, females and total runaway group

SCALE	ADJ	ACH	IS	DVL	SOM	D	FAM	DLQ	WDL	AN	PSY	HPR	SSK
MALE	98	66	69	64	60	77	58	106	65	67	73	74	67
FEM	86	58	49	57	58	71	63	101	63	63	70	65	63
TOTAL	89	60	53	58	59	72	62	102	63	64	71	67	64

Table 3

Profile type classification of adolescent runaways

TYPE	Freq	%	DSM - III diagnosis
1	0	0.0	(WNL)
2	0	0.0	(SPIKE)
3	3	4.9	Organic Brain Syndrome, Pervasive Developmental Disorder, Mixed Specific Developmental Disorder, Adjustment Disorder with Disturbance of Conduct
4	8	13.1	Conduct Disorder - Undersocialized Aggressive, Specific Developmental Disorder, Attention Deficit Hyperactivity Disorder

5	0	0.0	Mental Retardation, Pervasive Developmental Disorder, Adjustment Disorder with Disturbance of Conduct
6	0	0.0	Specific Developmental Disorder, Adjustment Disorder with Disturbance of Conduct
7	8	13.1	Conduct Disorder - Undersocialized Aggressive, Attention Deficit Hyperactivity Disorder, Major Depression
8	3	4.9	Attention Deficit Hyperactivity Disorder, Pervasive Developmental Disorder, Developmental Language Disorder
9	5	8.1	Dysthymia
10	26	42.6	Conduct Disorder - Undersocialized Aggressive, Attention Deficit Hyperactivity Disorder, Adjustment Disorder with Disturbance of Emotions

11	4	6.5	Attention Deficit Hyperactivity Disorder, Adjustment Disorder with Disturbance of Conduct
12	0	0.0	Specific Developmental Disorder, Adjustment Disorder with Mixed Disturbances of Emotion and Conduct, Attention Deficit Disorder with/without Hyperactivity
EXIT	4	6.5	
Total	61	100.0	

Classification Rate = 93.4%

FIGURE 1

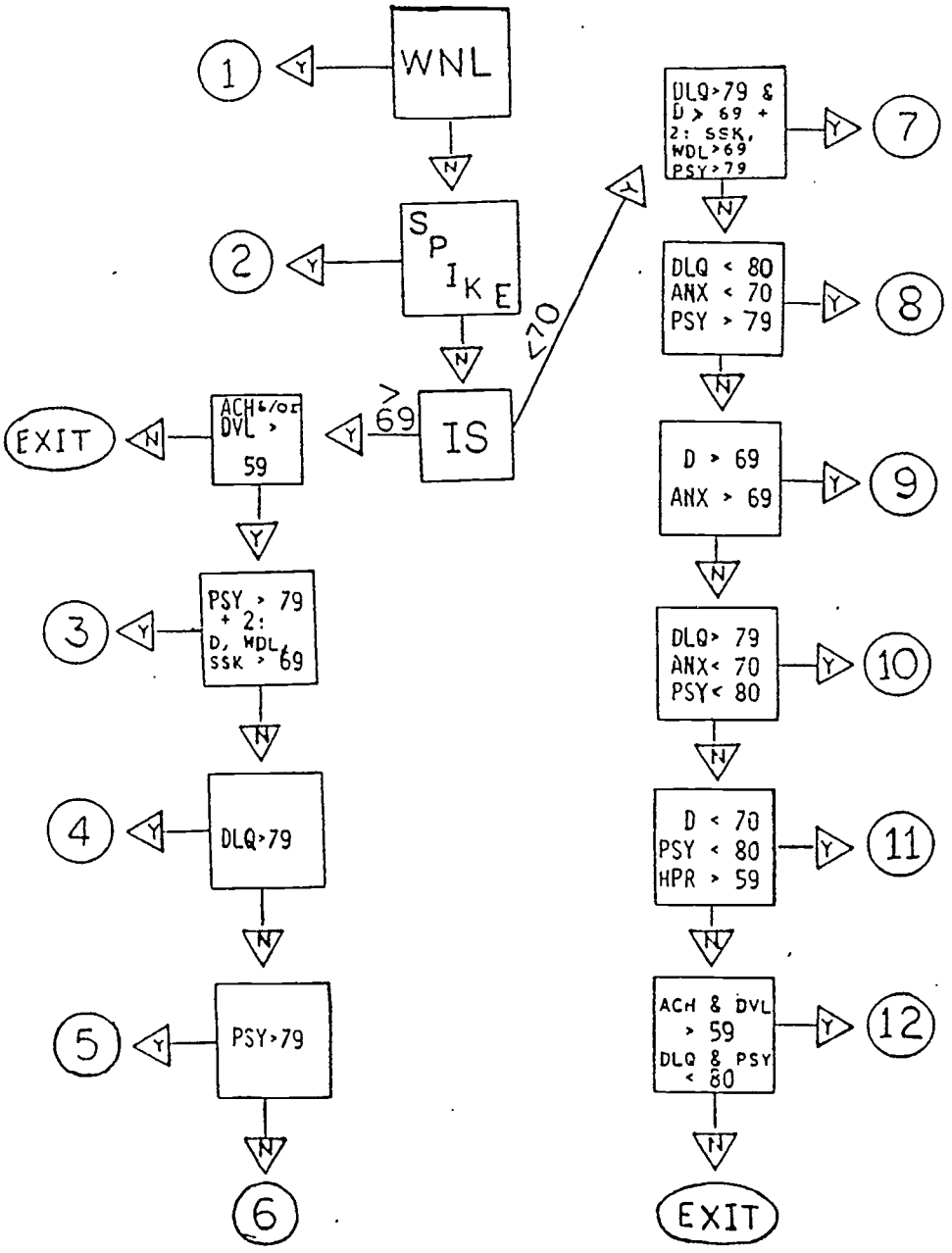
WNL
1
Y
N
SPIKE
2
IS
>69
<70
ACH &/or DVL > 59
EXIT
PSY > 79 + 2: D, WDL, SSK > 69
3
DLQ>79
4
PSY>79
5
6
DLQ>79 & D > 69 + 2: SSK, WDL>69 PSY>79
7
DLQ < 80 ANX < 70 PSY > 79
8
D > 69 ANX > 69
9
DLQ> 79 ANX< 70 PSY< 80
10
D < 70 PSY < 80 HPR > 59
11
ACH & DVL > 59 DLQ & PSY < 80
12
EXIT

FIGURE 2

PROFILE TYPE 10

The pattern of scale elevations in this child's profile is classified as a Profile Type 10. Children who obtain this classification are often significantly older than the average child referred to mental health clinics, with problems typically begining during school years or adolescence. Parent, teacher, and clinician observation suggests a child or adolescent with *pervasive eternalizing problems* that have proven very difficult to manage. *Parents do not trust* these children; they manifest a *bad attitude*, are *argumentative*, often *associate with similar troubled youth*, and behave in an *irresponsible* manner. *Stealing, lying, pervasive disobediance of rules, truancy*, and/or *aggression to peers and siblings* may be present. In contrast to other children who obtain a child guidance evaluation, these children demonstrate relatively fewer internalization or emotional problems.

These children are often referred at a relatively older age for a clinic evaluation at the insistance of

societal agencies, such as *schools* or the *criminal justice system*. *Depressive symptoms*, more often seen for younger children and females, are usually reactive (short-term and mild) and result from the possible consequences of their *acting-out behavior*.

Teachers describe these children as *unmotivated, underachieving, defiant of authority, disruptive, impulsive*, and *easily distracted within the classroom*. They, in turn, may be viewed by such children as hostile. Clinicians may report behaviors indicative of serious violations of social convention, including vandalism, running away from home, *involvement with the police*, and *drug or alcohol abuse*. Clinicians also note that these children and adolescents may be defensive when they are interviewed.

Parental inconsistency in limit-setting and *marital or family conflict* may be present. *Inconsistent discipline* may result in *inadequately developed impulse control mechanisms*. The mothers of these children may be seen as *overly strict disciplinarians*, or discipline may be described as overly permissive. These *mothers may be viewed by their children as hostile and*

rejecting. Family dysfunction, particularly dissolution, is proposed as a cause of problems for the majority of these children. *Patterns of family interaction may be cold and distant and communication between family members may be lacking.*

Feelings directed toward family members are often viewed as causitive of problems. These children are usually described as *chronically angry because of family interactions.* Anger may be directed particularly toward mothers. They may fear loss or abandonment by parents and they *may feel rejected by parents, sad about their fathers,* and *unloved by their mothers.*

As preadolescents, these children may attend regular classrooms or may qualify for special education services for the emotionally impaired. When evaluated at clinics, Profile Type 10 children and adolescents obtain mean estimates of ability and achievement within the average range. Adolescents *adjudicated delinquent*

often obtain this profile type. This child's problems may meet the criteria for one or more of the following diagnoses: *Conduct Disorder, Undersocialized Aggressive, Attention Deficit Disorder with Hyperactivity, and Adjustment Disorder with Disturbance of Emotions.*