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ABSTRACT
                An extensive review of the adolescent runaway
literature indicated inconsistent findings regarding the presence,
severity, and chronicity of psychopathological behavior among this
high-risk group. Three experiments were conducted to address these
issues using one personality measure, the Personality Inventory for
Children (PIC). The results of the first experiment indicated that
the PIC Typology was able to correctly classify over 93% of the
runaway subjects with identified psychopathologies of Conduct
Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Adjustment
Disorder, Major Depression, Dysthymia, Organic Brain Syndrome,
Pervasive Developmental Disorder, and Developmental Disorders. No
subjects were identified as Within-Normal-Limits. Experiment Two
indicated that the runaway group was not significantly different from
an outpatient sample or from a Day Treatment Program (partial
hospitalization) sample. Both clinical samples evidenced increasing
severity of psychopathology. The third experiment indicated that the
runaway group was not significantly different from a sample diagnosed
Conduct Disorder on 11 scales of the PIC. The results of this study
support the utility of the PIC as an initial screening measure only
and for identifying the degree of psychological dysfunction that
runaways and their families may be experiencing. (Contains 34
references.) (TS)

Identifying the presence, severity, and

chronicity of psychopathological behaviors associated

with adolescent runaways using the Personality

Inventory for Children

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Running head: IDENTIFYING PSYCHOPATHOLOGICAL

Whether behaviors associated with adolescent runaways were indicative of psychopathology has been a much discussed issue in the runaway literature. As early as 1968 the adolescent runaway was viewed as having significant emotional and behavioral problems. The Diagnostic and Statistical Manual of Mental Disorders-II (DSM-II) (American Psychiatric Association, 1968) had the diagnostic category, Runaway Reaction. Discriptors of this diagnosis were running away, timidity, immaturity, feeling rejected by one's parents, having few friends, and having poor problem-solving skills (Jenkins, 1969).

A review by Adams and Munroe (1979) was critical of the literature on the psychopathology associated with adolescent runaways. They concluded that the psychopathological behaviors associated with adolescent runaways could just as well be the consequence of running away rather than being the precipitant of it. The extant research did not support psychological profiles as being adequate predictors of runaway behavior (Adams & Munroe, 1979).

Similarly, a recent review by Burke and Burkhead (1989) concluded that significant psychopathology was not related to runaway behavior. They noted, in fact, that the diagnostic category, Runaway Reaction, had been deleted from the DSM-III (APA, 1980). A failing of the Burke and Burkhead review was that none of the reviewed articles on psychopathology was dated later than 1983.

Presence of Psychopathological Behaviors

The research has indicated that some of the behaviors associated with adolescent runaways may be indicative of the presence of psychopathology. Some noted behaviors were stealing (Edelbrock, 1980), truancy (Nye, 1980), using alcohol and drugs (Maar, 1984), suicidal tendencies (Novy & Donahue, 1985), having been physically abused (Harris, 1980), and sexually abused (Hughes, 1981). The results of the National Network of Runaway and Youth Services (NNRYS) survey (NNRYS, 1985) supported some of the above research findings. The NNRYS surveyed approximately 50,000 youth in 210 runaway facilities and found that some of the primary presenting problems were depression, suicidal tendencies, alcohol and drug

problems, physical abuse, sexual abuse, and the generic
category-severe psychological problems. The most recent
survey by the NNRYS (1991) essentially replicated their
1985 findings. 50,000 youth in 146 runaway facilities
were surveyed. They found that 46% of the youth had a
substance abuse problem, with 14% being addicted to a
substance. Thirty-one percent reported suffering
physical abuse and 21% reported being sexually abused.
Sixty-one percent reported being depressed, with 21%
having suicidal ideations.

Severity of Problems

While there has been increasing evidence that some
of the behavior of adolescent runaways was indicative
of the presense of psychopathology, few studies had
been conducted to determine the severity of the
behavior. Those studies that had been conducted,
operationally defined severity by comparing runaways to
known clinical groups or indicating that running away
was a known variable of an identified clinical group.

One study (Rohr, 1991) used a standardized measure
of child and adolescent psychopathology, the
Personality Inventory for Children-Revised (PIC-R)
(Wirt et al, 1984), and compared a sample of adolescent

runaways to an outpatient sample and a control sample.
The outpatient sample had DSM-III diagnostic disorders
of depression, anxiety, adjustment reaction,
retardation, learning disability, psychosis, and
hyperactivity (Lachar, 1990). The control sample had
never run away from home nor had they received any
mental health services from a professional. The results
indicated that the runaway and outpatient samples were
significantly different from the control sample on the
hypothesized variables of the PIC-R scales Adjustment
(ADJ), Achievment(ACH), Depression(D), Family
Relations(FAM), Delinquency(DLQ), Social Skills(SSK).
The runaway sample was not significantly different
from the outpatient sample except on the
Delinquency(DLQ) scale. On this scale, the runaway
sample had a significantly higher mean score than the
outpatient sample, T102 versus T93, respectively.

Another study found that runaways were
overrepresented in a group of youth referred for
outpatient mental health services (Edelbrock, 1980).
There were 682 males aged 12 through 16 and 472 females
aged 12 through 16 who had a runaway history. They were
compared to a sample of 1300 non-referred youth. Using

the Child Behavior Checklist, Edelbrock (1980)
concluded that, based upon the runaway's Child Behavior
Profile patterns, they may need comprehensive services,
including long-term mental health services. In fact,
running away was viewed as a symptom of broader
syndromes of psychopathology.

In a third study, Cahill (1988), using the
Minnesota Multiphasic Personality Inventory (MMPI),
investigated the development of a scale for identifying
runaways. One sample consisted of 220 hospitalized
adolescents who had a history of running away.
Diagnostically, 56% of the inpatient runaways
experienced significant physical abuse and neglect, 65%
abused alchohol, 68% abused other drugs, and 29% had
attempted suicide. Of this group, 17% obtained a 4/8
high point code type which has clinical discriptors of
antisocial behaviors in combination with schizophrenic
symptomatoloy. Twenty-nine percent obtained a 4/9 code
type which includes the classic features of the
antisocial personality type. Only 16% of the comparison
group, inpatient non-runaways, obtained a high point
code type of 4/8 and only 11% obtained a 4/9 code type.

Cahill found that the difference between the inpatient runaways and nonrunaway sample was significant.

Chronicity of Problems

To assess the chronicity of the problems associated with runaways, longitudinal studies had been conducted. 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, had trouble with the law (Olson, 1977), and required the assistance of social service agencies for nervous and emotional problems (Olson, Liebow, Mannino, & Shore, 1980). In a more recent study (Windle, 1989), a four year follow-up of 14 and 15 year old runaways found that runaway status in early adolescece was associated with subsequent substance abuse, alcohol abuse, and school drop-out status (Windle, 1989).

Methodological problems

An extensive review of research on the presence,
severity, and chronicity of the behaviors associated
with adolescent runaways revealed some methodological
concerns regarding the research on runaways (Rohr,
1991). One problem was the recentcy of the data. Some
of the data was relatively old. A more recent sample of
adolescent runaways needed to be assessed. Another
concern was the validity and reliability of some of the
instuments used to assess the presence of diagnostic
symptoms thought to be characteristic of runaways. A
prior review of those instruments concluded that while
the reliability may be somewhat adequate, there was
little or no validity data and most of the instüments
did not reflect reflect the range of problems/behaviors
associated with adolescent runaways. An instument with
few psychometric limitations, norms for both genders,
and scales that reflect the range of problems of
runaways should be used. Another concern was the lack
of focus in the research on runaways. The research was
inconsistant and not concerted. What seemed lacking was
a conceptual orientation to guide and focus the
research endeavers. The research should provide

theoretical and empirical direction to understanding
the runaway phenomenon. These findings should be of
applied and utilitarian value to those professionals
working with runaways. A final concern was that the
reviews were equivocal in their findings on whether
psychopathology was associated with the adolescent
runaway. Therefore, the purpose of this study will be
to assess a recent sample of adolescent runaways, using
one psychometrically sound instrument (PIC) to
determine if psychopathology is present, how severe it
is, and if it is chronic.

Method

The identification of the presence of
psychopathological behavior will be investigated by
applying the Personality Inventory for Children (PIC)
Profile Typology classification system to the target
group. This system yeilds an objective cluster
analytically derived interpretation, with corresponding
tentative DSM-III diagnoses (Kline, Lachar, & Gdowrki,
1987).

Determining the severity of the problems associated
with this sample of runaways will be investigated by

comparing the target group to two known clinical
groups, an outpatient sample and a Day Treatment
Program (partial hospitalization) sample.

The chronicity of the problems associated with this
sample of runaways will be investigated by comparing
the target group to a clinical group of adolescents
with chronic behavior problems: a group whose primary
DSM-III or DSM-III-R diagnosis was Conduct Disorder.

Experiment 1

Research Question

Will a sample of adolescent runaways obtain scale
scores on the Personality Inventory for Children
indicative of psychopathology or will the scale scores
be Within-Normal-Limits?

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
eligible 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. 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 were

similar to the survey findings of the NNRYS surveys

(1985; 1991) as mentioned above.

Additional similarities existed between this

sample and national estimates on runaways regarding

age, gender, and racial identity. 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 was the most dissimilar.

{ PLACE TABLE 1 ABOUT HERE }

Instrument

The PIC is a 600 item, parent informant, multidimentional measure of child and adolescent behavior, affect, and cognitive ability. 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).

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 were used for
those protocols that had just a single scale elevation,
TYPE 2 "spike" profiles. Lachar and Gdowski (1979) had
developed an actuarial system designed to render
interpretive hypotheses or rather assign behavioral
correlates to PIC T scores. Differing behavioral
correlates were associated with ranges of scores. For
instance, with the ADJ scale the same interpretation
was given to any scale score 60T and above. Whereas,
with the DLQ scale differing interpretations were given

to scale scores between 80-89T, 90-99T, greater than

99T and greater than 109T Procedure

To classify an individual youth's PIC profile,

follow down the chart (Figure 1) until the PIC T score

satisfies the requirements and the profile is

classified as that corresponding 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). 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 (Lachar & Gdowski, 1979a).

Results

Presense of Psychopathology

The PIC classification system was applied to the mean PIC scale profile of the male and female groups (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.

{ PLACE TABLE 2 ABOUT HERE }

The classification system was also 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 (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 other profile TYPES (3,4,5,7,8,9,11), while
indicating that behavioral/conduct problems
predominate, also indicate the possible presence of
other serious 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. The PIC psychological profiles
were indicative of the presence of psychopathology and
the scale scores were not Within-Normal-Limits.

Discussion

By using a standardized measure of adolescent
psychopathology, a very different profile of the
adolescent runaway emerged. It is one of emotional

disturbance. None of the profiles were Within-Normal-Limits or had only one scale elevated. But, as Adams and Monroe (1979) have reported, was the emotional disturbance a precipitant to running away or a consequence of the episode itself? They further argued that running away was a normal reaction to severe stressors in an adolescent's life, indicating that the youth may have been disturbed prior to running away, in which the running away is symptomatic. Or the running is a coping strategy of a "normal" person in an adverse situation. Brennon, et al (1978) have argued that the experience during the runaway episode itself was traumatic and negative. They found that 23% of runaways reported negative and traumatic experiences such as hunger, cold, fear, rape, being beaten, robbed, and jailed with undesirable adults. This perhaps indicates that the mental health problems were a response to the trauma experienced during the runaway episode. One asset of the PIC is that it is a parent informant test. In the case with this sample of runaways, the parent completed the test prior to the first therapy session with their child. That is, the parent answered questions regarding their childs' behavior which

occured prior to the youth running away, and without
knowledge of the events that may have occurred during
the runaway episode itself. This studys' findings may
lend some creedence to the youth being emotionally
disturbed prior to running away. While running away may
be a wise, logical response to perceived threat or
crisis (abuse, parental psychopathology, neglect,
etc.), the conclusions of this experiment indicates,
that the adolescent who runs away from home, may have
had mental health problems prior to leaving home. How
severe those emotional difficulties may have been was
the focus of the next experiment.

<div align="center">Experiment 2</div>

Research Question

Will there be a significant difference between an
adolescent sample of runaways when compared to an
outpatient sample of adolescents and a Day Treatment
Program (DTP) sample of adolescents?

Subjects and Data Collection

The runaway group was discribed in the first
experiment.

The outpatient comparison group was a random
sample of 60 subjects who were from a larger sample of

1226 subjects seen at an outpatient clinic in a
midwestern city in 1979 for problematic behavioral and
emotional adjustment (Lachar, 1990). Runaway history
was not specifically identified in this data set. This
was compensated for by eliminating all subjects with a
diagnosis of Conduct Disorder, since running away is a
criteria for this diagnosis. This was done prior to
inclusion in the sample. The age range was 13 through
17 with a mean age of 14.7. Thirty-one (50.8%) were
white and 49.2% (30) were black. 50.8% (31) were male
and 49.2% (30) were female. Each subject had been given
a DSM-III (APA, 1980) diagnostic classification.
Categorically, 11 (18.3 %) had a depressive disorder,
nine (15.0 %) had an anxiety disorder, 16 (26.7 %)
had an adjustment reaction, five (8.3 % were mentally
retarded, three (5.0 %) had learning disabilities,
six (10.0 %) had a psychotic disorder, and nine
(16.7%) were diagnosed with a hyperactivity disorder.

The other comparison group was taken from
consecutive admissions, between 1986 through 1991, at a
University based Day Treatment Program (partial
hospitalization). A random sample of 60 subjects ranged
in age from 13 through 17 with a mean age of 14.7.

Forty-one (68.3%) were male and 19 (31.7%) were female.
Forty-nine (81.7%) were white and 11 (18.3%) were
black. None of these subjects had a history of running
away. These subjects had DSM-III (APA, 1980) and DSM-
III-R (APA, 1987) diagnostic classifications (primary
diagnosis) based upon a complete psychological and/or a
psychiatric evaluation and whose case was reviewed by a
multidisciplinary team. Specifically, three (5.0%) had
a Schizophrenic Disorder, seven (11.6%) had Major
Depression, one (1.7%) had Bipolar Disorder, one (1.7%)
had Social Phobia, 23 (38.3%) had Dysthymia, four
(6.7%) had Separation Anxiety Disorder, three (5.0%)
had Post Traumatic Stress Disorder, one (1.7%) had
Depressive Disorder-NOS, six (10.0%) had a Conduct
Disorder, one (1.7%) had Intermittant Explosive
Disorder, two (3.3%) had Overanxious Disorder, three
(5.0%) had Oppositional Defiant Disorder, and five
(8.3%) had Attention Deficit Hyperactivity Disorder.
Instrument

A discription of the PIC was provided in the first
experiment. Previous research indicated that the PIC
scales of Adjustment (ADJ), Achievement (ACH),
Depression (D), Family Relations (FAM), Delenquency

(DLQ), and Social Skills (SSK) were highly predictive
of runaway behavior (Rohr, 1991). The Psychosis scale
(PSY) was added in this study as a measure of severity.
The PSY scale was constructed to discriminate children
with psychotic symptomotology from normal, behaviorally
disturbed nonpsychotic, and retarded children (Lachar,
1982).

Results

A ONEWAY ANOVA and post-hoc analysis was performed
comparing the target group to an outpatient sample and
a Day Treatment Program sample on the PIC variables
ADJ, ACH, D, FAM, DLQ, SSK, and PSY. The results
indicate that the Runaway sample is not significantly
different (p > .05) from the Outpatient group. The
Runaway group is also not significantly different (p >
.05) from the Day Treatment Program sample except on
one variable, DLQ, $F(3,237)=40.80$, $p < .05$. The
critical value of Scheffe's test is 3.98. On this
variable, the Runaway sample has a higher mean score
than the Day Treatment Program sample, 102T versus 89T,
respectively.

Discussion

The delivery of mental health services to adolescents can lie on a continuum of least to most restriction. That is, outpatient services are provided in a least restictive enviornment while inpatient services are provided in a most restictive setting. The Day Treatment Program (partial hospitalization) services is middle alternative to these extremes (Pruit and Kiser, 1991). Accessing mental health services depends, in part, upon the severity of the mental health problem. By comparing the runaway sample, whose behavioral characteristics are indicative of the presence of psychopathology, to two clinical groups with known mental health problems that vary in severity, an estimate of the severity of the problems of runaways can be made. The results indicate that the PIC psychological profiles of the adolescent runaway is not significantly different than the psychological profile of an adolescent Outpatient or Day Treatment Program sample. The possibility exists that runaways may be even more emotionally/behaviorally impaired than the DTP sample as measured by the DLQ scale alone.

A finding of Experiment 1 was that the modal diagnosis for the runaway group was Conduct Disorder. Antisocial child behavior includes aggressive acts, vandalism, lying, theft, firesetting, running away, and acts that reflect major social rule violations (Kazdin, 1992). A persistant pattern of such behaviors is referred to as Conduct Disorder. A diagnosis of Conduct Disorder during adolescence portends continued dysfunction in adulthood (Rutter and Giller, 1983). If the behavior of adolescent runaways is of a chronic type, one way of determining the chronicity is to compare them to a group with a known chronic behavioral problem, Conduct Disorder. This will be the focus of experiment 3.

Experiment 3

Research Question

Will there be a significant difference, on the PIC variables ADJ through SSK, between a sample of adolescent runaways and a sample of adolescents diagnosed Conduct Disorder?

Subjects and data collection

The Runaway sample was described in Experiment 1.

The comparison group consisted of adolescents from outpatient and a Day Treatment Program settings who had a primary DSM-III or DSM-III-R diagnosis of Conduct Disorder. The total number of subjects was 20. They ranged in age from 13 to 17 with a mean age of 14.8. Sixteen (80%) were male and four (20%) were female. Twelve (60%) were white and eight (40%) were black.

Instrument

The PIC was described in Experiment 1.

Results

A ONEWAY ANOVA was carried out comparing the target group to the Conduct Disordered group on the PIC variables ADJ through SSK. The results indicate that the target group is not significantly different (p > .05) from the Conduct Disordered group on any of the 13 clinical scales of the PIC-R, ADJ through SSK.

Discussion

The determination of the chronicity of the problems runaways experience was done in a manner similar to that determining the severity of the runaways problems. The results indicate that the psychological profiles (behaviors and symptoms) of adolescent runaways were quite similar to the

psychological profiles of adolescents with a known

clinical diagnosis of Conduct Disorder. This lack of

significant difference stongly suggests that the

psychopathological behaviors that runaways exhibit, if

untreated, may persist into adulthood and they will be

of a chronic and dysfunctional type. According to

Rutter and Giller (1983) conduct disordered

adolescents, as adults, are far more likely to show

persisting psychiatric and social impairment.

General Disscussion

The PIC Profile classification system is an

empirically derived typology of child and adolescent

psychopathology. The application of the typology to the

runaway group resulted in over 93% of the protocols

being classified. The tentative diagnoses associated

with the modal classification Type 10, were Conduct

Disorder, Attention Deficit with Hyperactivity

Disorder, and Adjustment Disorder. The possible

diagnosis of Conduct Disorder substantiates therapists'

intuitive and clinical experience with runaways and the

problems they present. Attention must also be given to

other possible diagnoses associated with the target

group. They include Organic Brain Syndrome, Pervasive

Developmental Disorder, Depression (Major, Dysthymia)
and Developmental Disorders. There were no protocols
that were a Type 1, WITHIN NORMAL LIMITS. Also, no
protocols had only one scale elevated, Type 2 or SPIKE.

The comparison of the runaway group to two known
clinical groups indicated that the severity of the
problems runaways experience fell along a continuum.
Pruit and Kiser (1991) presented a continuum of care
model of mental health services for children and
adolescents. They stated that the mental health
services were prevention, outpatient, partial care
(Day Treatment Progam), inpatient, and residential
treatment centers. It can be argued that the degree of
severity typically associated with those five systems
of care are mild, mild-moderate, moderate-severe,
severe, and chronic long term, respectively. Given this
association and that the runaway group was not
significantly different from the outpatient and Day
Treatment Program groups, the severity of the problems
that runaways experience may range from mild to
moderately severe and perhaps even severe. Severe is
mentioned because the runaway group had a significantly

higher mean score on the Delinquency (DLQ) scale than did the Day Treatment Program group.

Runaway Program staff are continually challenged by a persistent increase of serious mental health problems presented by their clients. Some pertinent findings of the NNRYS (1985) survey were that runaway programs were seeing youth, who presented with problems that were more psychologically serious than those youth of 5 to 6 years earlier. They noted a need for more professionally trained staff. This survey also voiced a need for more comprehensive mental health services to meet the needs and problems of these severely troubled youth and their families. Those problems were parental drug use, victimization issues, youth alcohol and drug use, suicide, and serious psychiatric problems (NNRYS, 1985).

This study demonstrates that the psychological profile associated with the adolescent runaway is symptomatic of psychopathology. The degree of psychopathology may range from mild (outpatient) to moderately severe (Day Treatment Program), with a constellation of problems (Conduct Disorder) that can be quite resistant to therapeutic intervention and can

be eventually severely debilitating. While Chwast,
(1977) advocated that therapy with adolescent runaways
be conducted on the premises of the runaway program,
the severity of the problems that runaways present with
may require services that the runaway program cannot
feasibly provide. What a runaway program can provide,
in addition to their current services, is competant
psychological assessment of psychopathology and a
triage protocol in order to access the mental health
services needed for intervention with the adolescent
and their family on a systemic level.

This study has several limitations that may
restrict generalization of the findings. Stratified
random samples were not always collected for this
study. Time restictions prohibited further collection
of data. The time invested in collecting the data was
already two years. Runaway programs are crisis
facilities and the nature of such programs sometimes
may prohibit parents completing assessment instruments,
despite their value and utility (Rohr, 1991).
Additionally, the behaviors associated with runaways
may meet the criteria for numerous psychopathologies.
But, the PIC is not a substitute for a complete

psychological evaluation. The results of this study support the utility of the PIC as an initial screening measure only and for identifying the degree of psychological dysfunction that runaways and their families may be experiencing.

Recomendations

The use of the PIC, as part of an assessment process, in Runaway Programs or other mental health settings (community mental health centers, schools) that work with runaways, is stongly encouraged. The clinical information generated by the PIC and it's interpretive methods about the youth, parents, and families would greatly aid in treatment planning and the type of referral needed for follow-up services. In addition, the professional, legal, and ethical restrictions on using personality tests necessitates runaway programs having qualified staff to administer and interpret the instument. The use of qualified mental health professionals in runaway programs would address the reccomendations by the NNRYS survey (1985).

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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

SEX   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

PIC profile type classification of adolescent runaways

Profile Freq %   DSM-3 diagnosis

Profile	Freq	%	DSM-3 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

or 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%

Classification Rate: 93.4%

FIGURE 1