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Perceptions of the Family Environment and Youth Behaviors: Alcohol-Abusing Runaway Adolescents and Their Primary Caretakers

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Abstract

Research suggests family disturbance is highly correlated to adolescents running away from home. However, given methodological challenges, few studies assess parent report of the family situation and instead, rely primarily on adolescent self-report. This article reports the findings of parents' and runaway adolescents' reports on several behavioral dimensions. Substance-using runaway adolescents completed measures about their family environment and adolescent problem behaviors. Of 119 adolescents, 49 of their parents also completed measures at intake. Adolescents perceived a more negative family environment than did their parents, and parents rated their youth as having more externalizing problems than did the youth themselves. Findings are consonant with prior research showing a relationship between parental distress and child problems. Contrary to prior findings, this sample of parents did not report significant alcohol use, and there was no relationship between their use and their child's use. Implications for future research and family therapy are discussed.

Keywords

adolescent; family; runaway and homeless youth; parent responses; substance use

Because many studies on runaway and homeless youth conduct surveys of youth on the streets or in shelters and document associated problem behaviors, parent data are difficult to obtain given tracking and consent procedures. The current study helps address this gap through evaluating both parent and adolescent reports for treatment-seeking youth residing in local runaway shelters.

Runaway youth not only face family challenges of abuse and high levels of family conflict but also have high rates of related problem behaviors. Researchers have documented high rates of alcohol consumption and illicit drug use, teen pregnancy, victimization, and prostitution (Embry, Stoep, Evens, Ryan, & Pollock, 2000; Hoyt, Ryan, & Cauce, 1999; Whitbeck, Hoyt, & Bao, 2000). An estimated 70% to 95% of runaway and homeless youth have substance use problems (Booth & Zhang, 1997; McLean, Paradise, & Cauce, 1999). Smart and Adlaf (1991) studied 145 street youth and found that almost 50% reported current alcohol problems at a clinically significant level and 9% drank alcohol daily. This compares to a nonrunaway sample reported in the Monitoring the Future (1997) study in which 1.8% of those aged 12 to 17 reported daily use of alcohol.

Adolescent homelessness is defined by the U.S. Department of Health and Human Services as “a situation in which a youth has no place of shelter and is in need of services and shelter where he or she can receive supervision and care” (Runaway and Homeless Youth Program/Title 45, 1999, p. 300). *Runaway* is defined as “away from home without the permission of his or her parents or legal guardian or is absent from home or place of legal residence at least overnight without permission” (Runaway and Homeless Youth Program/Title 45, 1999, p. 300). This article refers to the sample of adolescents as runaways because these youth were shelter dwelling and were not without appropriate supervision or care.

Theoretical Background and Treatment for Adolescent Substance Users

Though family systems theory is a useful model for understanding youth running away from home, relatively few studies have examined parental, in addition to adolescent, reports of the family environment and other problems (Youngstrom, Loeber, & Stouthamer-Loeber, 2000). More generally, family systems theory purports that adolescent problem behaviors, including substance abuse, running away, and other externalizing problems are symptoms of maladaptive family interaction patterns (Jacob, 1987). Indeed, the literature shows that the family plays a role in the development, maintenance, and recovery from substance use disorders (Gorsuch & Butler, 1976; Hops, Duncan, Duncan, & Stoolmiller, 1996; Stanton, Todd, & Associates, 1982), and research on family factors that influence addiction has been influential in developing intervention strategies for distressed marriages and family situations. These researchers and theorists have asserted that we will never understand either the individual or psychopathology unless we understand relationships and interactions (Christensen & Arrington, 1987). Identification of the problems that parents and youth perceive in the family, and their agreement on these perceptions, can provide rich information for guiding therapists' intervention strategies.

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Research on the treatment of adolescent substance abusers has lagged behind that of adult substance users (Williams & Chang, 2000). A recent review of randomized clinical trials involving family therapy with adolescent substance abusers identifies 13 studies (Ozechowski & Liddle, 2000). Given that research shows a connection between the family and the development of problems among youth, family intervention strategies with adolescent substance users is an important focus. The family intervention field for adolescent substance users has increased its focus on using a multisystemic framework and includes Liddle's (2000) multidimensional family therapy and Henggeler, Schoenwald, Borduin, Rowland, and Cunningham's (1998) multisystemic therapy. These frameworks are based on Bronfenbrenner's (1979) theory of social ecology in which individuals are viewed as being nested within a complex of interconnected systems that encompass individual, family, and extrafamilial (peer, school, neighborhood) factors. Behavior is seen as the product of the reciprocal interplay between the child and these systems and of the relations of the systems with each other (Henggeler & Borduin, 1995). Multisystemic treatments are based on the recognition that substance use and other related problem behaviors derive commonly from many sources of influence and occur in the context of multiple systems (Henggeler et al., 1991). Long-term positive outcomes are best achieved through addressing these multiple systems in the intervention approach.

Intervention With Runaway Youth

Although research on runaway youth has increased in the past 10 years, the literature on treating runaway youth is more remarkable for what we do not know than for what we do know, and it has been noted that runaway and homeless youth are an underserved and understudied

population (Rotheram-Borus, Feldman, Rosario, & Dunne, 1994). Shelters, and shelter-based programs, have been the only intervention noted in the literature for runaway youth, and few studies specify the treatment received by youths while in these shelters (Teare, Furst, Peterson, & Authier, 1992). At two local shelters in New Mexico, most runaway youth who reside in the shelter return to a home situation (approximately 95%), which suggests that their family situation has not disintegrated beyond the point of intervention.

To date, no outcome studies evaluating family intervention strategies with runaway substance-abusing youth have been published. However, information on family environment characteristics and different family members' perceptions of these characteristics can assist in the development of such approaches.

Family Factors Associated With Adolescent Substance Use

Low family support and control (as perceived by youth) was linked with higher alcohol use in a meta-analysis conducted by Foxcroft and Lowe (1991). Parenting practices have shown value in predicting adolescent delinquency (e.g., Patterson & Stouthamer-Loeber, 1984). Specifically, poor parental monitoring and inconsistent discipline have been identified as key parenting practices associated with adolescent substance use and other problem behaviors (e.g., Dishion, Capaldi, Spracklen, & Li, 1995; Forehand, Miller, Dutra, & Chance, 1997). Parental psychopathology (e.g., depression, anxiety, parental substance use, and stress) is associated with substance use disorder, depression, and conduct problems among youth (Burbach & Borduin, 1986; Downey & Coyne, 1990; Merikangas, Rounsaville, & Prusoff, 1992; Patterson, 1980; Thomas & Forehand, 1991). Parent substance use was identified as a risk factor for adolescent substance use. Hops et al. (1996) in a longitudinal study, examined 763 families during a 6-year period and found a predictive serial relation between parent substance use and the use patterns of their adolescents.

Parent Reports on the Family

Among runaway youth residing at local shelters, Whitbeck and Hoyt (1999) obtained information from both the parent and adolescent. These researchers found that parents of runaways scored themselves significantly lower on measures of parental monitoring than did other parents. These parents reported that they were less apt to know where their child was and with whom and reported that they provided less support and more rejection to their children. They were also less likely to establish and enforce a curfew. Interestingly, both runaway youth and their parents reported less effective parenting compared to families of nonrunaway youth.

Adolescent Reports on the Family

Information obtained from runaway and homeless youth suggests that lack of a supportive family might be the single largest factor associated with youth running away and homelessness (Whitbeck & Hoyt, 1999). Runaway youth have reported significantly more family conflict, less cohesion, less parental love, and more maltreatment than matched housed adolescents (Wolfe, Toro, & McCaskill, 1999). Similarly, Schweitzer and Hier (1994) found that runaway and homeless adolescents, compared to a housed sample, reported more emotional deprivation as assessed on the Parental Bonding Instrument (PBI) (Parker, Tupling & Brown, 1979) and social and cultural deprivation as assessed on the Family Environment Scale (FES) (Moos & Moos, 1986). Runaway youth cited poor communication in the family and the desire to have improved communication (Teare et al., 1992). In fact, youth staying in runaway shelters reported that their greatest needs concerned living arrangements, family relationships, and communication with their parents.

Many runaway and street-living youth report leaving families because of physical and sexual abuse and neglect. Studies vary widely in the reported incidence of this trauma. Adolescent

reports of admitted sexual abuse range from 21% to 60% (Molnar, Shade, Kral, Booth, & Watters, 1998; Whitbeck, Hoyt, & Ackley, 1997), and reported physical abuse ranges between 16% and 40% (Molnar et al., 1998; Unger, Kipke, Simon, Montgomery, & Johnson, 1997). In comparison, the overall national average was 1% in 2001 (U.S. Department of Health and Human Services, 2001). Between 50% and 70% of runaway youth report that they were neglected while living in the home (Whitbeck & Hoyt, 1999). In one study, 41% of youth cited parents not caring about them as a reason for leaving home (Whitbeck & Simons, 1990).

Current Study

We conducted our literature search using the Psychinfo database that includes more than 1 million citations of journal articles, books, dissertations, and technical reports. We did not find other studies that specifically examined the family environment characteristics for alcohol-abusing runaway adolescents and their families. Although there has been much research on adolescent substance use in general, researchers have noted that even within this area, research fails to examine the role of family characteristics (Anderson & Henry, 1994; Stephenson, Henry, & Robinson, 1996). Understanding the family environment is an important first step for developing family-based interventions.

The need to evaluate the consistency or inconsistency between parent and runaway youth self-report is great given that many researchers secure self-report information from runaway youth only. Many family systems treatment approaches share the focus on communication and discrepant family perceptions as the basis for intervention (Gladding, 2002). Whether the reports on the youth's behavior and family environment converge among family members or are more informative for providing information to the therapists on family members' perceptions remains to be explored.

This study is part of a larger study evaluating the effectiveness of family therapy—functional family therapy (Alexander & Parsons, 1982) and ecologically based family therapy (Slesnick, 2003)—over time with alcohol-abusing runaway youth and their families. Return rate of information from parents was too low at follow-up (for this and the larger study) to examine, longitudinally, parent-adolescent corroboration; thus, this article focuses solely on pretreatment information. The aim of the current study was to examine the consistency and difference between adolescent and parent reports of the family environment and of adolescent problem behaviors. Few studies are available to guide our predictions as convergent validity for adolescent report of family environment and other problem behaviors among runaway youth has been relatively unexplored. We expected weak correlations between adolescent and parent self-report and believed that the adolescent report of the family environment would be more negative than parent report. Moreover, we expected adolescents would view their own problem behaviors as less severe than would their parents. An adolescent's perception of parental bonding and a primary caretaker's reported psychological distress might help elucidate the relationship between adolescent and parent perceptions and will be discussed.

Method

Participants

Families in this study were recruited for a larger project examining family therapy outcome (NIAAA Grant No. R01AA12173). To be eligible for the program, youth had to be between the ages of 12 and 17, reside at a local runaway shelter, and meet DSM criteria for alcohol abuse or dependence or have used alcohol 10 of the past 90 days. Only alcohol-abusing youth were included because this project was funded under a federal initiative to evaluate behavioral treatment interventions for alcohol-problem adolescents (RFA #AA-98-003, Treatment for Adolescent Alcohol Abuse and Alcoholism). Families had to reside within a 60-mile radius of

the research site. Of the 119 adolescents who completed the measures, 49 (41%) parents responded, and so only those youth whose parents responded were included in this study.

Shelter environment—The two runaway shelters are the only shelters available in the area for runaway youth. The youth served by the shelters are primarily from an urban, southwestern city with a population of approximately 600,000. Each shelter provides approximately 12 beds, and adolescents are able to reside at a shelter for up to 30 days. Counselors on staff and shelter workers are available for talking with the youth, although a brochure reporting on a local shelter's mission states “Our task as youth services providers is not correcting the ‘pathologies’ of troubled youth, but rather as providing for the successive needs of young people.” The shelters primarily provide food, shelter, clothing, crisis intervention, and assist with placement.

Adolescent demographics—This study included 20 male and 29 female adolescents. These adolescents averaged 15.18 ($SD = 1.25$) years old and reported an average of 4.82 runs in their lifetime. The ethnic distribution of the adolescents was 4 (8%) Native Americans, 2 (4%) African Americans, 21 (43%) Hispanics, 18 (37%) Anglos, and 4 (8%) “Other.” Seventeen (35%) adolescents reported sexual abuse and 22 (45%) reported physical abuse.

Primary caretaker demographics—Of the 49 parents who responded, 37 mothers responded, 5 fathers responded, 6 caregivers reported being neither the adolescent's mother nor father, and 1 caregiver did not respond regarding her relationship to the adolescent. Of the caregivers that were neither the biological mother nor father, 3 reported being the adolescent's grandmother, 2 reported being an aunt, and 1 reported being a stepmother. The primary caretaker's average age was 42 ($SD = 9.34$) and reported being married an average of 1.42 times ($SD = 0.91$). The ethnic distribution of these parents was 5 (10%) Native Americans, 2 (4%) African Americans, 18 (37%) Hispanics, 23 (47%) Anglos, and 1 (2%) Other.

Procedure

A research assistant approached youth identified by shelter staff as potentially eligible participants for the project. Youth were engaged and screened for participation using the eligibility criteria as a guide. Those passing the screening criteria were then scheduled for an assessment at the shelter within 24 hours following consent from both the youth and parent. The interviewer then proceeded to administer the Diagnostic Interview Schedule for Children (DISC) (Shaffer, 1992) sections on alcohol, marijuana, and other substances to the youth. Youth had to meet diagnostic criteria for alcohol abuse or dependence for participation in the larger study. Those not receiving an alcohol diagnosis continued with treatment as usual through the shelter. Those meeting the criteria for participation in the study continued with the assessment battery. The adolescent's assessment battery required approximately 3 hours and the youth received U.S.\$25 when the assessment was completed. The questionnaires within the packet were counterbalanced to minimize potential order effects. The primary caretaker's assessment was shorter, approximately 30 minutes, and he or she was reimbursed U.S.\$10 for completion of the packet. Primary caretakers completed the assessment information at the shelter or were mailed the assessment packet with a stamped and addressed return envelope included. Primary caretakers who did not return the assessment packet were called by a research assistant, and attempts were made to schedule an appointment to have the interviewer review the questionnaires with the primary caretaker, either at their home or at the shelter. All participants in the study completed the assessment packet prior to receiving the project intervention.

Materials

A demographic questionnaire, assessing a set of core variables used to characterize and compare samples included in the study, was administered. The demographic items included

age, gender, self-identified ethnicity, parent and sibling information, education, income sources, school information, legal history, and physical and sexual abuse history. The instruments described below were included in the study as these areas have been shown to be negatively affected in adolescent runaway youth and families.

The Youth Self-Report (YSR) of the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1982) provided a standardized format to quickly elicit reports of children's behavior across a wide range of problem areas. The 120-item scale assesses behaviors in children associated with delinquency, aggression, attention problems, somatic complaints, thought problems, and social problems. The measure is highly reliable and effectively discriminates between children referred to clinics for problem behavior and nonclinic children. Test-retest reliability was .69 across a 6-month interval, and criterion validity ranged from .75 to .82 (Achenbach & Edelbrock, 1982). The YSR provides factor scores for Internalizing (depressed behavior, social withdrawal, somatic complaints, and schizoid-obsessive behavior) and Externalizing (hyperactive behavior, sexual problems, delinquency, and aggressiveness), as well as a Total Behavior Problems score. The primary caretaker was administered the parent form of the CBCL (Achenbach & Edelbrock, 1982).

The Computerized Diagnostic Interview Schedule for Children (CDISC) (Shaffer, 1992) is a computerized structured interview containing 263 items pertinent to a comprehensive psychiatric diagnostic interview based on *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (American Psychiatric Association, 1994) criteria. CDISC was developed specifically to diagnose children and adolescents, is prominent in the field (Winters & Stinchfield, 1995), and has been used with runaway and homeless youth (Morgan & Cauce, 1999; Mundy, Robertson, Robertson, & Greenblatt, 1990; Warheit & Biafora, 1991). Test-retest reliability ranged from .41 to .86 and validity scores ranged from .37 to .80 (Fisher et al., 1993; Jensen et al., 1995). As the larger study required youth to have an alcohol use diagnosis, CDISC was used to that end.

The PBI (Parker, Tupling & Brown, 1979) consists of 25 items and is a measure of two important dimensions of parent child relationship—perceived parental care versus rejection, and control versus autonomy. It has good reliability in both clinical and nonclinical samples (correlations ranging from .63 to .88) and has demonstrated construct and predictive validity with correlations ranging from .51 to .78 (Klimidis, Minas, & Ata, 1992; Parker, 1983; Parker et al., 1979). The PBI requires the respondent to score his or her parents using a 4-point scale.

The FES (Moos & Moos, 1986) is a commonly used and well-standardized family assessment instrument. It is composed of 90 true-false items and consists of 10 subscales that measure the following social-environmental characteristics of families: Conflict, Cohesion, Achievement Orientation, Active-Recreational Emphasis, Control, Expressiveness, Intellectual-Cultural Emphasis, Independence, Moral-Religious Emphasis, and Organization. Internal consistencies have ranged from .61 to .78 and test-retest reliabilities from .73 to .86.

To assess psychological distress among the primary caretakers, the Brief Symptom Inventory (BSI) (Derogatis, 1993; Derogatis & Melisaratos, 1983) was administered. The 53-item test identifies the level of distress that a person is experiencing at a specific point in time (usually within the past 7 days) and is developed from the longer Symptoms Checklist-90-Revised (SCL-90-R). Nine primary symptom dimensions are measured using a 5-point scale: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. More than 250 studies attest to the validity of the instrument and internal consistency ranges from .71 to .85 for the nine primary symptom dimensions. Test-retest reliability has ranged from .68 and .91 with a 2-week interval between

tests (Derogatis & Lazarus, 1994). The global severity index (GSI) score is used as the dependent variable in this study.

The primary caretaker completed the Alcohol Use Disorders Identification Test that was developed by the World Health Organization to identify persons whose alcohol consumption has become hazardous or harmful to their health (Babor et al., 1992; Saunders, Aasland, Babor, De La Fuente, & Grant, 1993). It is a 10-item screening questionnaire with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 on problems caused by alcohol. It has shown good reliability (test-retest, internal consistency) ranging from between .81 to .93 and validity (content, criterion and construct; Claussen & Aasland, 1993; Saunders et al., 1993). Scores range from 0 to 40, with a score of 8 indicating a strong likelihood of hazardous or harmful alcohol consumption.

Results

Primary Caretaker Responses

Only 41% of the primary caretakers completed the requested information, even though numerous attempts were made by research assistants to acquire the data. Because of this large number who did not respond, potential differences in responses between primary caretakers who did respond at pretreatment and those who did not respond were investigated using *t* tests or chi-square (for categorical measures). No differences were found for any adolescent characteristics, including age, gender, ethnicity, report of physical or sexual abuse, incidence of suicide attempt(s), or number of times runaway. Groups (responders vs. nonresponders) did not differ by the adolescent's report of his or her father or mother's ethnicity. No drug or alcohol use measures, adolescent psychological characteristics (e.g., depression, number of non-substance abuse related CDISC diagnoses), or any family characteristics (e.g., bonding, conflict tactics, YSR subscales, FES subscales) differed by primary caretaker response.

Although the following analyses include only cases with both primary caretaker and adolescent responses ($N = 49$), because of missing data for individual measures, the number of responses differs between measures (see Table 1).

Gender Differences

Male adolescents were older than female adolescents ($M=15.75$, $SD = 1.21$, $M = 14.79$, $SD = 1.15$) for males and females, respectively, $t(47) = 2.81$ $p < .01$. Males reported lower overprotection from their primary caretaker(s) on the PBI ($M= 14.45$, $SD= 8.55$) versus females ($M= 20.14$, $SD= 9.20$), $t(46) = -2.18$, $p < .05$. No gender differences were found for any alcohol or drug use measures, family characteristics (FES), or child behavior problems (YSR) (all $p > .10$).

Parental Bonding

Using the PBI, adolescents rated their parents on overprotection and bonding/care. Parental overprotection averaged 17.77 (9.28), out of a possible score of 39, whereas parental bonding/care averaged 21.38 (9.69), out of a possible score of 36. The two scales were not correlated ($r = -.07$).

Parental Psychological Distress and Alcohol Use

As a measure of psychological distress, the primary caretaker completed the BSI. The GSI was 0.75 (0.65). Testing this mean against the mean reported for adult "nonpatients" in the BSI manual (Derogatis, 1993) indicates that the primary caretaker's GSI was significantly higher than the norm, $t(46) = 4.75$, $p < .001$. Parents self-reported minimal alcohol use, AUDIT score $M = 2.79$, $SD = 5.32$, with a range of 0 to 31. Four parents reported having a score of 8 or

above, indicating problem alcohol consumption. In addition, there was no relationship between the parent's BSI and AUDIT score and the adolescent's alcohol use.

Relation Between Primary Caretaker and Adolescent Responses

FES—Bivariate correlational analyses were completed to examine the relationship between adolescent and primary caretaker reports (see Table 1). Primary caretaker and youth responses concerning the family environment were not always correlated. Primary caretaker and youth responses regarding perceived family conflict, cohesion, achievement orientation, active recreation orientation, control, expressiveness, and independence subscales were uncorrelated (all $p > .05$). In general, adolescents perceived the family environment more negatively on these subscales than did primary caretakers. Primary caretakers and adolescents' responses regarding the Intellectual-Cultural Orientation ($r = .31, p < .05$), Moral-Religious Emphasis ($r = .53, p < .001$), and Organization ($r = .47, p < .01$) were all significantly related.

Primary caretaker and adolescent mean differences were tested using t tests. On the Conflict, Cohesion, Expressiveness, Intellectual-Cultural Orientation, and Organization subscales, primary caretaker and adolescent means differed: for Conflict, $t(43) = 3.80, p < .001$; for Cohesion, $t(43) = -3.40, p < .001$; for Expressiveness, $t(43) = -4.78, p < .001$; for Intellectual-Cultural Orientation, $t(43) = -3.70, p < .01$; for Organization, $t(43) = -3.05, p < .01$. For the other five subscales (Achievement Orientation, Active-Recreational Orientation, Control, Independence, and Moral-Religious Orientation), means did not differ between primary caretakers and adolescents ($p > .10$; see Table 1).

YSR/CBCL—Primary caretaker and youth responses on the YSR/CBCL were variably related. On the Externalization (Delinquency and Aggression subscales) and Problem subscales (Internalizing, Externalizing, Social, Thought and Attention Problems subscales), primary caretaker and youth scores were not correlated ($p > .10$), with adolescents reporting fewer externalization problems but more overall problems. On the Internalization subscale (Withdrawn, Somatic, and Anxiety/Depression subscale), primary caretaker and youth scores were correlated ($r = .34, p < .05$; see Table 1).

Primary caretaker and child mean differences were tested using t tests. On both the Externalization and Problem subscales, primary caretaker and child means differed: for Externalization, $t(42) = -2.60, p < .05$; for Problem, $t(42) = 3.53, p < .01$. Primary caretaker and adolescent means did not differ for the Internalization subscale ($p > .10$).

Runaway episodes—To examine the relationship between running away and perceptions, those adolescents who reported one episode of running away were compared to adolescents who ran away more than one time. Between-subjects t tests were used to determine if there were any differences in the family environment for these two groups. No differences in any of the YSR or FES subscales, or on the PBI were found between these groups. In addition, no differences in frequency of adolescent drug use (from the Form-90) or in any parent characteristic (age, number of times married, alcohol use, or psychological distress [BSI]) were found (all $p > .10$).

Discussion

This study sought to examine the relationship between primary caretaker and runaway youth reports of the family environment and child behaviors. Our predictions were partially supported in that primary caretaker and youth reports did not converge for the majority of scales. In general, primary caretakers perceive their youth's externalization problems to be more severe than the youth perceives, and primary caretakers perceive the family environment as less problematic than do the youth.

Family Environment

Primary caretaker and youth perceptions of the family environment were correlated for the FES subscales of Intellectual-Cultural, Moral-Religious, and Organization. FES subscales Intellectual-Cultural and Moral-Religious fall within the personal growth domain, whereas Organization relates to system maintenance. Compared to normal samples, subscale scores for Intellectual-Cultural, Moral-Religious, and Organization showed that these families, although scores converged, reported much less emphasis on personal growth, and both primary caretaker and youth reported high levels family disorganization. However, among these subscales, the primary caretaker and youth mean scores on the Intellectual-Cultural and Organization subscales differed significantly, although the mean scores were nonsignificant on the Moral-Religious subscale.

Consistent with a family systems understanding of adolescent problems, both primary caretakers and youth reported elevated FES subscale scores compared to the normative sample of nondistressed families, with the exception that primary caretakers reported near normal levels of family conflict. Mean differences between primary caretaker and youth reports were significant for 5 of the 10 FES subscales. Adolescents reported more extreme negative perceptions on each of the subscales.

These findings are similar to those of Shek (1999) in which adolescent perceptions of the family environment are generally more negative than primary caretaker perceptions. Grotevant and Cooper (1986) interpreted discrepancies in family perceptions as part of the normal developmental process of individuation by the adolescent. However, in this sample of runaway youth and their caretakers, though perceptions differed, all scales reached levels indicating distress (with the exception of primary caretaker-reported family conflict). In sum, similar to the findings of others (Schweitzer & Hier, 1994; Wolfe et al., 1999), runaway youth and their primary caretakers reported a wide range of problems on the FES family environment variables. Of particular interest is that overall, youth perceived a more distressed family environment than their primary caretaker did.

Perhaps this finding can be interpreted in light of the adolescent's role and position in the family and social hierarchy. Adolescents have less power in their families and society given their lower social status. They might perceive the environment more negatively than the primary caretaker partially because they are less able to effect changes to that environment, and they have little recourse when the environment collapses. That is, when the environment collapsed, adolescents left or were removed from their home. Understandably, residing at a runaway shelter, while primary caretakers remain in their home, may further influence family perceptions in a negative direction for youth.

Adolescent Problem Behaviors

Primary caretaker and youth reports of youth behaviors converged on the YSR/CBCL Internalization subscale, but not on the Externalization or Total Problem subscales. Mean subscale summary scores reported by both primary caretakers and adolescents were in the clinical range of problem severity. Youth reported fewer severe externalization problems than did their primary caretakers, though youth reported a more severe overall problem score than did their caretakers. Youngstrom et al. (2000) and Seiffre-Krenke and Kollmarr (1998) found the opposite in that caregiver-youth dyads tended to show less agreement about internalizing than externalizing. Our findings then are counterintuitive. One might expect that observable behaviors (delinquency and aggression) would show more agreement between dyads than would less observable behaviors as measured by the Internalization subscale. Possibly, given the level of family problems that include running away from home, primary caretakers perceive their youth's externalizing problems as more severe than the child perceives the problems.

Potentially, youth perceive the family environment to be integral to problems they are experiencing, whereas primary caretakers perceive the youth's misbehavior as the root of the problems that they currently experience. The Total Problem subscale includes less observable behaviors in the youth including thought, social, and attention problems to which the primary caretaker may not be privy.

The GSI score of the BSI for primary caretakers is elevated compared to a normal sample, indicating that the primary caretakers of these youth report more distress on the nine symptom dimensions. Research on nonrunaway adolescent populations shows that increased primary caretaker or familial stress is associated with decreased levels of agreement between primary caretaker and child problems (Kolko & Kazdin, 1993). Primary caretakers with mood disorders also show tendencies to report greater levels of pathology in their children than do independent observers (Chilcoat & Breslau, 1997; Frick, Silverthorn, & Evans, 1994). In addition, our findings are consonant with prior research showing a relationship between parental distress and child problems. However, contrary to findings suggesting a relationship between parental alcohol use and adolescent use, our sample of parents did not report significant alcohol use, and there was no relationship between their use and their child's use. We did not collect information on parent's illicit drug use patterns, which could show a different pattern of relationship. Overall, our findings of low agreement between primary caretakers and youth, including greater parent report of adolescent externalizing problems, are similar to the findings of other researchers.

Implications

The findings of the current study provide some insight into primary caretaker and youth perceptions of the family environment and youth behaviors. However, several limitations of the study should be considered. First, information is based solely on self-report. Independent observers would be needed to objectively rate family and youth behaviors. Each family member may be biased, and the family environment may fall somewhere in between two extremes. Alternatively, independent observers might rate behaviors consistent with either the primary caretakers' or the youths' perceptions. Without independent observation, investigation of these possibilities is difficult. Second, this study did not include a control group of nonrunaway and non-substance users, as it was a part of a larger controlled clinical trial. It is not possible to determine if the findings may be associated with runaway status, substance use, or simply adolescence more generally. Further research to more fully tease out this relationship will be necessary.

A third limitation is that data from youth and primary caretakers were obtained at one point in time. Longitudinal data during a period of months or years would provide a clearer understanding of the underlying reasons for discrepant perceptions and would be more sensitive to developmental stages in both the youth and family. In addition, as only 41% of primary caretakers completed the self-report packet, we cannot be confident that primary caretakers who responded were not different from the primary caretakers from whom we did not receive information. In sum, primary caretakers who did not respond might perceive more or less severe problems in the family and in their youth or may be qualitatively different in some other area of functioning. Finally, participants in this project were alcohol-abusing adolescents residing at a runaway shelter. Thus, the findings may not generalize to non-alcohol abusing runaway youth or to those youth and families who do not seek services from a social service agency.

However, even given these limitations, this information might be useful to those who serve families or youth who runaway from home. Family members may have varying perceptions of problems, and the therapists need to be aware that differences in perceptions occur and do not necessarily represent "truth." For example, Wolfe et al. (1999) suggested that runaway youth may exaggerate family problems to justify leaving home or because they were angry

with their primary caretakers who asked them to leave. It is equally plausible that parents might minimize family problems, perhaps because of a tendency toward social desirability or as a defensive response. In fact, both parents and youth are at a heightened level of stress when the youth is residing at a shelter, and the timing of the assessment may therefore not elicit responses representative of usual family interaction.

These perceptions might represent truth to the individual reporting on the behaviors. Addressing varying perceptions in treatment may be a useful starting point in family systems therapy, as was suggested by other researchers (e.g., Noller & Callan, 1988). As noted by Shek (1999), identification of differences is also important as it may assist the therapist in understanding the underlying mechanisms contributing to the perceived differences. Underlying mechanisms might include idealistic expectations of the family or its members, defensiveness, or tendencies toward blame. These discrepancies in perception might initiate discussions regarding misunderstandings and negative attributional sets.

Such a focus on communication is the basis for the systemic intervention approach developed by the Mental Research Institute—a communications-based model that Don Jackson created in Palo Alto, California, in 1958 (Gladding, 2002). Family systems interventions share this focus on communication (Gladding, 2002), asserting that one can best be understood via the study of the family's communications. Focusing on pathology may be less important than the focus on relationships and perceptions of such relationships (Ray, 2000). According to the family systems model, pathological behavior is synonymous with pathological communication (Jacob, 1987). Multisystemic family models also share the systemic focus on interpersonal communication. Thus, although it may be maladaptive behavior that brings the family into therapy, family therapists must recognize and deal with the cognitive and affective realms of family functioning. This includes communication and attributional sets (Alexander & Parsons, 1982) but also the behavioral realms and related larger systems that affect the family.

Conclusion

Although runaway youth and primary caretakers report similarity along several family environment and youth problem behavior dimensions, dissimilarities were also found. These dissimilarities may best be understood and addressed using a systemic communication-based approach in which the family therapist addresses divergent perceptions in the therapy context. Such focus on the observed discrepancies (adolescent externalizing problems and family environment perceptions) might facilitate the discussion of those issues that interfere with effective family interaction and communication. The focus on family communication and differing perceptions can perhaps be best conceptualized as a part of the larger multisystemic treatment approach that focuses on multiple areas such as parental distress and parenting practices, school and juvenile justice problems, and peer relationships. Given that adolescent problems are multiply determined (Jessor & Jessor, 1977), interventions that address multiple areas of functioning may have the most chance at leading to positive outcomes.

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Table 1
Adolescent and Primary Caretaker Means, Standard Deviations, and Correlations for Each of the Youth Self-Report of the Child Behavior Checklist and Family Environment Scale Subscales

Measure and Subscale	N	Adolescent M (SD)	Parent M (SD)	r	t
YSR/CBCL					
Externalization	43	28.77 (9.99)	34.67 (12.08)	.10	-.260*
Internalization	43	19.86 (9.38)	19.05 (11.41)	.34*	0.44
Problem	43	76.42 (21.54)	60.81 (26.02)	.27	3.53***
FES					
Conflict	44	5.23 (2.51)	3.52 (2.24)	.22	3.80***
Cohesion	44	4.77 (2.81)	6.45 (2.04)	.11	-3.40***
Achievement Oriented	44	5.68 (1.96)	5.61 (1.54)	.23	0.21
Active Recreational	44	4.41 (2.04)	4.14 (2.36)	.03	0.59
Control	44	5.32 (2.00)	4.93 (1.52)	.24	1.16
Expressiveness	44	4.09 (1.71)	5.57 (1.66)	.26	-4.78***
Intellectual-Cultural Orientation	44	3.77 (2.31)	5.27 (2.27)	.31*	-3.70***
Independence	44	5.61 (1.83)	5.91 (1.60)	.13	-0.86
Moral-Religious Orientation	44	4.82 (2.30)	5.18 (2.23)	.53***	-1.10
Organization	44	4.50 (2.20)	5.55 (2.20)	.47	-3.05***

YSR/CBCL = Youth Self-Report of the Child Behavior Checklist; FES = Family Environment Scale.

*
p < .05.

**
p < .01.