

A Brief Measure of Psychological Health and Well-Being

Initial Validation of the Schwartz Outcome Scale for an Adolescent Inpatient Sample

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Abstract: The present study evaluated whether the Schwartz Outcome Scale-10 (SOS-10), a well-validated self-report measure of psychological health and well-being in the adult population, would tap this construct similarly in an adolescent inpatient sample. This study looked to compare scores on the SOS-10 with the Youth Self-Report (YSR) and the Inventory of Interpersonal Problems (IIP), two well-validated self-report measures of behavioral problems and interpersonal distress. A total of 154 adolescent psychiatric inpatients completed the SOS-10, YSR self-report, and the IIP-32 at or within a day of admission to the inpatient unit. The results showed that the SOS-10 was negatively related to the subscales of the YSR and the scales of the IIP-32. Although just the first step in the validation of this measure for the adolescent inpatient population, the SOS-10 shows promise as a measure of psychological health and well-being and, possibly, as a brief outcome measure.

Key Words: Schwartz Outcome Scale-10, adolescent, inpatient, outcome, assessment.

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There is growing pressure, both scientifically and economically, to document adolescent inpatient treatment effectiveness (Joint Commission on Accreditation of Healthcare Organizations, 1997; Lyons et al., 1997; Sederer et al., 1996). Identifying factors to aid in the improvement of inpatient treatment is critical for maximizing treatment efficacy. Most studies to date investigating adolescent inpatient treatment are retrospective in nature, relying on follow-up with discharged patients and chart review. These studies also suffer from high dropout rates and lack systematic information regarding symptoms, demographics, and diagnosis (Blanz and Schmidt, 2000). There are fewer studies looking at adolescent inpatient treatment than in the adult counterparts. Mash and Hunsley (2005) state that when assessing child and adolescent disorders, it is important to also assess broader life-context factors including psychological well-being, peer relations, and family relations.

In a recent review, Bettmann and Jaspersen (2009) looked at the treatment outcome literature of both adolescent inpatient settings and residential treatment settings. The review included both kinds of settings because of the similarities in patient severity and around-the-clock care. They were also combined because the outcome literature on each was sparse. This is surprising considering that inpatient

treatment of adolescents is not only the most expensive but also the most disruptive. Adolescents are taken away from their social support system and placed with other adolescents who are behaviorally dysregulated (Blanz and Schmidt, 2000).

The lack of prospective research on inpatient treatment is only part of the issue. Many studies use idiosyncratic measures (with unproven reliability and validity data) and often operationalize successful treatment as symptom reduction and or the reduction of pathological behavior or cognitions. Although this is important, Keyes (2002, 2007) states that the polar opposite of psychological distress is not the absence of such but psychological health and well-being. He believes that the mental health field should be focused not solely on decreasing psychopathology and symptoms but also on enhancing psychological health and a sense of well-being to help the person flourish.

This study looks to investigate a potential brief, easy-to-administer and score measure of psychological health and well-being that has been used as a treatment outcome measure in studies using adult samples. In the current study, we looked to investigate if the Schwartz Outcome Scale-10 (SOS-10; Blais et al., 1999) can also be used in a fast-paced adolescent inpatient service where many of the patients seen have difficulty attending for long periods of time and there are large time demands on the staff. The hope is that this measure may provide a more practical alternative to longer, more detailed measures of functioning.

The SOS-10 (Blais et al., 1999) is a measure of psychological health and well-being that is used to assess outcome and treatment response across varying forms of treatment modalities (*i.e.*, psychotherapy, electroconvulsive therapy, psychopharmacology) and with diverse patient samples (*i.e.*, inpatient, outpatient, emergency department, acute psychiatry units, substance use patients). The items of the SOS-10 were initially developed from a comprehensive literature review, an expert panel from several different mental health domains (*i.e.*, psychology, psychiatry, neurosurgery), and focus groups of patients. This original process produced 81 items sensitive to measuring change that people might experience as a result of successful treatment. The items were administered to patients in various settings (*i.e.*, outpatient psychotherapy clinic, psychopharmacology clinic, an acute inpatient psychiatric unit, and a nonpatient sample of hospital employees). As a result, the SOS-10 was reduced to a nonredundant 10 items. The final version of the SOS-10 asks respondents to rate the 10 items pertaining to their life and well-being based on how they have been feeling the past 7 days (Blais et al., 1999, p. 372). The items of the SOS-10 are scored from 0 (never) to 6 (all of the time or nearly all of the time). The measure produces a total score where high scores are reflective of better functioning (*i.e.*, more life satisfaction and higher levels of well-being). Psychometric analysis has found that the SOS-10 has strong internal consistency (Cronbach's $\alpha = .96$), with item-scale correlations ranging from 0.74 to 0.90. Total scores from the SOS-10 have demonstrated that it is associated

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with scores for measure of mental health, fatigue, life satisfaction, desire to live, positive and negative affect, self-esteem, hopelessness, alexithymia, five-factor model, interpersonal dependency, and mental health, demonstrating the construct validity of this measure (Blais et al., 1999; Dragomirecka et al., 2006; Haggerty et al., 2010a, 2010b, 2012; Laux and Ahern, 2003; Rivas-Vazquez et al., 2001; Young et al., 2003).

Studies have shown that the SOS-10 is well suited for measuring psychological health and well-being in a number of diverse settings and with diverse patient populations (Dragomirecka et al., 2006; Rivas-Vazquez et al., 2001; Young et al., 2003). Its psychometric properties make it an attractive measure for use in research as well, because it is versatile and quick and easy to administer and score. The SOS-10 has illustrated good test-retest correlations, Cronbach's alphas above 0.85, and construct validity with a variety of clinical and psychological well-being measures and discriminates between clinical and nonclinical samples (Baity et al., 2009; Blais et al., 1999; Hilsenroth et al., 2001; Haggerty et al., 2010a, 2010b; Young et al., 2003; Owen and Imel, 2009).

The use of SOS-10 has been broadened and increased since its development. The measure has been translated into Spanish (Rivas-Vazquez et al., 2001) and Czech (Dragomirecka et al., 2006) and has demonstrated good psychometric properties. The utility of the measure has been extended outside the psychiatry population to normative samples, including college undergraduates (Haggerty et al., 2010a; Young et al., 2003).

Although the SOS-10 has been well established and validated as a measure of general well-being and life satisfaction in patient populations, it is important to demonstrate its applicability to newer populations. This includes the assessment of outcome in an adolescent psychiatric inpatient sample. This would further broaden its use and also allow for future comparisons between different populations (*i.e.*, normative, psychiatric outpatient, psychiatric inpatient, substance use services, adult and adolescent services). The present study examines associations between the SOS-10 and two well-validated measures of distress, the Youth Self Report (YSR; Achenbach, 1991) and the Inventory of Interpersonal Problems-32 (IIP-32; Horowitz et al., 2000; Soldz et al., 1995a). The advantages of using a measure such as the SOS-10 for outcome assessment with adolescent inpatients is that it is only 10 items and is easier for adolescents who often demonstrate difficulty with frustration tolerance and attention. Its short

length and ease of scoring make it potentially appealing for staff on adolescent inpatient services.

In the present study, we anticipate that the SOS-10 will be negatively correlated to the IIP-32 scales and the IIP-32 total score as well as the YSR self-report scales. This is expected because both of these measures tap interpersonal distress and pathology.

METHODS

Participants

The sample consisted of 154 psychiatric inpatients, 75 men and 79 women, admitted to the Nassau University Medical Center's (NUMC's) Adolescent Psychiatric Inpatient Unit. The patients were between the ages of 13 and 17 years, with a mean (SD) age of 15.9 (1.102) years. The ethnic makeup of the sample was as follows: 44.2% Caucasian, 31.8% African-American, 16.9% Hispanic/Latino, 2.6% Asian, and 4.5% other. These patients were consecutively admitted to the adolescent psychiatric inpatient service at NUMC from July 2009 to May 2010. The diagnostic breakdown of the sample was as follows: 31% conduct disorder/oppositional defiant disorder, 6% impulse control disorder, 58% mood disorder, 1% posttraumatic stress disorder, and 4% psychosis.

Procedure

Each patient was given a self-report assessment packet containing the SOS-10, the IIP-32, and the YSR on or within 1 day of admission to the unit. The patients were given as much time as needed to complete the assessments, which were typically completed within 45 minutes. These assessments were done as part of the clinical assessment protocol of the unit, and the data for this study were gained through chart review. These assessment data were shared with the clinical treatment team during the next available morning team meeting. This information was used to help collaborate on treatment goals with the patient.

Measures

The SOS-10 (Blais et al., 1999) is a 10-item Likert-style self-report measuring psychological well-being and distress. Each item is scored on a scale from 0 to 6, yielding possible total scores from 0 to 60. Higher scores on the SOS-10 are representative of better psychological health and well-being. Research (Dragomirecka et al., 2006; Haggerty et al., 2010, 2012; Laux and Ahern, 2003; Rivas-Vazquez et al., 2001; Young et al., 2003) has shown that the SOS-10 is a valid and reliable measure of quality of life and psychological well-being. Coefficient alpha was 0.84.

The IIP-32 (Horowitz et al., 2000; Soldz et al., 1995b) is a 32-item inventory of distressing interpersonal behaviors the respondent identifies as "hard to do" (*i.e.*, behavioral inhibitions) or "does too much" (*i.e.*, behavioral excesses) on a 0 (not at all) to 4 (extremely) Likert scale. Items were derived from verbatim transcripts of patients' psychotherapy intake interviews. Subsequent analyses identified the current version, which conforms to the interpersonal circumplex, through the covariation among the eight IIP-C octant scales. These eight scales can be represented pictorially as a circle such that attributes adjacent to one another have more similarity and those across from one another have opposite qualities. Counterclockwise from the top of the circle, these subscales include a) domineering/controlling (PA), that is, being too controlling or manipulative in interpersonal interactions; b) vindictive/self-centered (BC); that is, being frequently egocentric and hostile in dealing with others; c) cold/distant (DE); that is, having minimal feelings of affection for, and little connection with, other people; d) socially inhibited/avoidant (FG); that is, being socially avoidant and anxious and having difficulty approaching others; e) nonassertive (HI); that is, having difficulty expressing one's needs to others; f) overly accommodating/exploitable (JK); that is, being gullible and easily taken advantage of by people; g) self-sacrificing/overly nurturant (LM); that

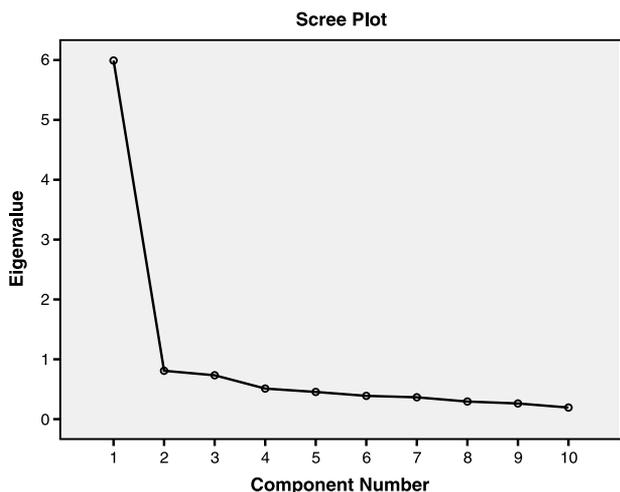


FIGURE 1. Scree plot of Schwartz Outcome Scale-10 principal component analysis.

TABLE 1. Means and Standard Deviations of SOS-10 and Item-Scale Correlations

SOS Item	Mean	SD	Ceiling Effects	Flooring Effects	Item-Scale Correlation
1	4.17	1.73	47	8	0.60
2	3.93	1.69	35	7	0.78
3	3.83	1.92	41	11	0.79
4	3.88	1.75	35	7	0.82
5	4.61	1.72	72	3	0.79
6	3.79	1.98	42	16	0.84
7	3.39	2.09	34	20	0.81
8	3.95	1.92	20	20	0.77
9	3.61	1.76	22	10	0.70
10	3.70	1.95	40	12	0.79

Cronbach $\alpha = 0.84$. Ceiling effects refer to the number of participants who gave a 6 for that item (highest score possible), whereas flooring effects refer to the number of participants who gave a 0 for that item (lowest score possible).

SOS-10 indicates Schwartz Outcome Scale-10.

is, being excessively selfless, generous, trusting, caring, and permissive in dealing with others; and h) intrusive/needy (NO); that is, imposing one's needs and having difficulty respecting the personal boundaries of other people. The IIP-32 has well-documented reliability and validity (Horowitz et al., 2000), with subscale alpha coefficients ranging from 0.76 to 0.88 and test-retest reliabilities ranging from 0.58 to 0.84 (total $r = 0.79$). Whereas the IIP-64 has eight items in each octant, the IIP-32 has four of the IIP-64's eight items in each octant. Validity evidence for the IIP-32 was illustrated by the positive association of the IIP-32 with the indices of negative mood such as anxiety and depression (Wei et al., 2003). The IIP has been reliably administered to adolescent samples (Brill, 2001; Brown and Wright, 2003; Fichman et al., 1994; Hansen and Lambert, 1996; Hill et al., 1998; Sheffield et al., 1995). Coefficient alphas for the scales of the IIP-32 and the total score ranged from 0.64 to 0.88.

The YSR (Achenbach, 1991) is a widely used self-report questionnaire designed to assess the behavioral problems and social competencies of children 4 to 18 years of age. The YSR is composed of 118 problem items and 20 competence items grouped into 11 problem scales (including 8 syndrome scales) and 4 competence scales. The YSR also yields two broadband, higher order psychopathology scales, internalizing and externalizing. The YSR is broadly used in both clinical and research settings because of its demonstrated reliability and validity, ease of administration and scoring, and applicability to clinical, nonclinical, and cross-cultural samples (Achenbach, 1991; Cohen et al., 1985; De Groot et al., 1994; Drotar et al., 1995; Sandberg et al., 1991). Coefficient alphas for the scales of the YSR ranged from .70 to .89.

RESULTS

Before we analyzed the data, we removed the participants who had total scores of 0 or 60 because this may demonstrate that the patient is not answering the items of the SOS-10 in a truthful manner. This resulted in two admission SOS-10s and one discharge SOS-10 score to be removed from the analysis. Because past research (Blais et al., 1999; Haggerty et al., 2010) has shown that the SOS-10 was unifactorial when used with adult patients, we wanted to investigate if this was true with an adolescent sample. A principal component analysis resulted in one factor with eigenvalues greater than 1. This factor had an eigenvalue of 5.99 and accounted for 60% of the total variance. Figure 1 illustrates the scree plot of the principal component analysis. All 10 items of the SOS-10 had factor loadings of 0.59 or higher. The adjusted item-to-scale correlations were also all higher than 0.60. These results are in line with past research on the SOS-10 with adult samples (Blais et al., 1999; Haggerty et al.,

2010). Table 1 lists the SOS-10 item means, standard deviation, ceiling and flooring effects, and item-to-scale correlations. An analysis of the items revealed that far more participants scored items at the highest possible score than the lowest possible score, and scoring on each item revealed a skew toward higher more healthy scores.

Table 2 lists the means and standard deviations for all the measures used in this study. Table 3 lists the means and standard deviations for male and female patients who completed the measure as well as the t -test results for sex differences. Independent t -test analyses of the SOS-10 revealed no significant sex differences ($t_{150} = -0.280$, $p = 0.780$). Furthermore, an analysis of variance computed for the SOS-10 revealed no significant ethnicity differences ($F_{4, 147} = 1.46$, $p = 0.216$). Pearson product-moment correlations between the SOS-10 scores and the comparative measures (*i.e.*, YSR and IIP-32) were then conducted to examine the various hypothesized relationships. Table 4 summarizes

TABLE 2. Means and Standard Deviations of Study Measures and Subscales

	<i>N</i>	Mean	SD
Anxious depressed	141	0.62	0.48
Withdrawn depressed	141	0.69	0.42
Somatic complaints	141	0.48	0.35
Social problems	141	0.46	0.36
Thought problems	141	0.73	0.31
Attention problems	141	0.89	0.38
Rule-breaking behavior	141	0.72	0.33
Aggressive behavior	141	0.69	0.36
Internalizing	141	0.60	0.38
Externalizing	141	0.71	0.31
SOS-10 total score	152	37.82	14.28
Domineering/controlled	150	1.24	0.93
Vindictive/self-centered	150	1.38	1.22
Cold/distant	150	1.56	1.25
Socially inhibited	150	1.54	1.18
Nonassertive	150	1.32	1.08
Overly accommodating	150	1.38	0.89
Self-sacrificing	150	1.51	1.04
Intrusive/needy	150	1.26	0.99
IIP total score	150	1.40	0.79

SOS-10 indicates Schwartz Outcome Scale-10; IIP, Inventory of Interpersonal Problems.

TABLE 3. Sex Differences in the Comparison Measures' Subscale Scores

Subscales	Score				Sex Difference Effect Sizes <i>T</i>
	Women		Men		
	Mean	SD	Mean	SD	
YSR					
AD	0.68	0.51	0.55	0.44	1.71
WD	0.74	0.44	0.65	0.40	1.16
SC	0.49	0.34	0.49	0.36	0.03
SP	0.46	0.37	0.48	0.35	0.31
TP	0.74	0.30	0.73	0.34	0.03
AP	0.84	0.37	0.95	0.37	1.66
RB	0.69	0.29	0.77	0.38	1.37
AB	0.66	0.35	0.74	0.38	1.36
I	0.64	0.39	0.56	0.37	1.17
E	0.68	0.28	0.76	0.34	1.53
IIP-32					
PA	1.12	0.99	1.37	0.86	1.66
BC	1.35	1.32	1.42	1.12	0.33*
DE	1.60	1.25	1.52	1.26	0.37
FG	1.52	1.20	1.58	1.16	0.29
HI	1.37	1.08	1.27	1.09	0.52
JK	1.53	0.90	1.24	0.86	1.99
LM	1.68	1.11	1.33	0.93	2.11*
NO	1.32	1.13	1.21	0.81	0.66**
Total	1.44	0.83	1.37	0.74	0.52
SOS-10	37.87	14.34	38.58	16.84	0.28

N = 75 women and 66 men. Two-tailed *t*-tests were used to assess sex differences. YSR indicate Youth Self Report; AD, anxious depressed; WD, withdrawn depressed; SC, somatic complaints; SP, social problems; TP, thought problems; AP, attention problems; RB, rule-breaking behaviors; AB, aggressive behavior; I, internalizing; E, externalizing; IIP-32, Inventory of Interpersonal Problems-32; PA, dominant/controlling; BC, vindictive/self-centered; DE, cold/distant; FG, social inhibition; HI, nonassertive; JK, overly accommodating; LM, self-sacrificing; NO, intrusive/needy; Total, IIP-32 total score; SOS-10, Schwartz Outcome Scale-10.
**p* < 0.05.
***p* < 0.01.

the correlations of the SOS-10 with the YSR, and Table 5 summarizes the correlations of the SOS-10 with the IIP-32. Pearson product correlations were computed for all relationships by using an alpha level of 0.05 for significance (two tailed). Correlational coefficients are

TABLE 4. Pearson Product Correlations Between SOS-10 and YSR

	<i>N</i>	SOS-10	
		<i>r</i>	<i>p</i>
Anxious depressed	139	-0.64	<0.000
Withdrawn depressed	139	-0.62	<0.000
Somatic complaints	139	-0.49	<0.000
Social problems	139	-0.52	<0.000
Thought problems	139	-0.39	<0.000
Attention problems	139	-0.42	<0.000
Rule-breaking behavior	139	-0.23	0.006
Aggressive behavior	139	-0.34	<0.000
Internalizing	139	-0.66	<0.000
Externalizing	139	-0.32	<0.000

SOS-10 indicates Schwartz Outcome Scale-10; YSR, Youth Self Report.

TABLE 5. Pearson Product Correlations Between SOS-10 and IIP-32

	<i>N</i>	SOS-10	
		<i>r</i>	<i>p</i>
Domineering/controlled	150	-0.30	<0.000
Vindictive/self-centered	150	-0.14	0.092
Cold/distant	150	-0.15	0.066
Socially inhibited	150	-0.20	0.014
Nonassertive	150	-0.11	0.167
Overly accommodating	150	-0.28	0.001
Self-sacrificing	150	-0.23	0.004
Intrusive/needy	150	-0.26	0.002
IIP total score	150	-0.26	0.001

SOS-10 indicates Schwartz Outcome Scale-10; IIP-32, Inventory of Interpersonal Problems-32.

considered to represent a small effect from 0.1 to 0.3, a medium effect from 0.3 to 0.5, and a large effect if greater than 0.5 (Cohen, 1988). Hemphill (2003) reported that mean effects greater than 0.30 occur only 33% of the time in psychology research.

In support of the hypotheses, the results revealed significant negative correlations between the SOS-10 total score and the YSR's measures of anxious depressed withdrawn depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behavior, aggressive behavior, internalizing, and externalizing. Significant negative correlations were also found between the SOS-10 total score and the IIP-32's measures of domineering/controlling, socially inhibited, overly accommodating, self-sacrificing, and intrusive/needy. Results revealed a significant negative correlation between the SOS-10 total score and the IIP-32 total score as well.

We also wanted to investigate the effect of age on scoring on the measures. Superficially, we wanted to see whether younger adolescents (13–15 years old) scored differently than older adolescents (16–17 years old) on the SOS-10. A Pearson product-moment correlation between age and the SOS-10 total score did not reveal a significant relationship (*r* = -0.03, NS). We divided the sample into two groups, with those 13 to 15 years of age in the first group and older adolescents (16–17 years old) into the second group. Our results showed no marked difference in scoring. Table 6 shows the

TABLE 6. Age Comparison of Correlations Between SOS-10 and YSR

	SOS-10	
	Patient Age	
	13–15 yrs (<i>n</i> = 43)	16–17 yrs (<i>n</i> = 96)
Anxious depressed	-0.70	-0.70
Withdrawn depressed	-0.62	-0.73
Somatic complaints	-0.56	-0.57
Social problems	-0.57	-0.64
Thought problems	-0.30	-0.55
Attention problems	-0.36	-0.57
Rule-breaking behavior	-0.22	-0.37
Aggressive behavior	-0.41	-0.45
Internalizing	-0.72	-0.75
Externalizing	-0.35	-0.48

SOS-10 indicates Schwartz Outcome Scale-10; YSR, Youth Self Report.

TABLE 7. Age Comparison of Correlations Between SOS-10 and IIP-32

	SOS-10	
	Patient Age	
	13–15 yrs (n = 49)	16–17 yrs (n = 101)
Domineering/controlled	–0.38	–0.37
Vindictive/self-centered	–0.11	–0.22
Cold/distant	–0.08	–0.27
Socially inhibited	–0.25	–0.27
Nonassertive	–0.32	–0.10
Overly accommodating	–0.40	–0.32
Self-sacrificing	–0.26	–0.26
Intrusive/needy	–0.28	–0.31
IIP total score	–0.34	–0.36

SOS-10 indicates Schwartz Outcome Scale-10; IIP, Inventory of Interpersonal Problems.

correlations between the SOS-10 and YSR scales for young adolescents and older adolescents separately. Table 7 shows the correlations between the SOS-10 and the IIP-32 for young adolescents and older adolescents separately as well. Our results also showed that younger adolescents (13–15 years old) had a mean score of 37.7 (14.4) and the older adolescents (16–17 years old) had a mean score of 37.9 (14.3). The Cronbach alpha was quite similar for the two different age groupings (0.923 for 13–15 year olds; 0.925 for 16–17 year olds).

DISCUSSION

The SOS-10 has been a well-validated measure of psychological health and well-being for the adult population. The SOS-10 is versatile in that it can be used with many different populations and with various treatment modalities. It is cost-effective and easy and quick to administer and score, making it very appealing to both clinician and researcher alike. In the current environment in which measuring outcomes to evaluate treatment is vital, this measure provides a practitioner and researcher the added benefit of being used in a number of different settings.

The goal of the present study was to evaluate whether the SOS-10 taps the same constructs (*i.e.*, psychological health and well-being) in an adolescent psychiatric inpatient sample as it has with various adult samples. This was one step in a series of validation studies evaluating whether the SOS-10 can be used as an outcome measure for psychiatric adolescent inpatients. The results reveal that the SOS-10 does indeed negatively correlate with commonly used measures of behavioral dysfunction and interpersonal distress. Although not all of the IIP-32 subscales significantly correlated with the SOS-10 score, all of the results were in the expected direction.

Our results revealed that the SOS-10 did not significantly correlate with the IIP-32 scales of cold/distant, vindictive/self-centered, and nonassertive. Although this was unexpected, as previously stated, they were in the expected direction (*i.e.*, negatively correlated) and two of the three were trending toward statistical significance. Possible reasons could be that many of the patients have a difficult time endorsing the items that tap these constructs because they are limited in their ability to see themselves in this way and want to present themselves better. Future studies would do well to evaluate whether certain diagnostic categories (*e.g.*, conduct disorder and oppositional defiant disorder) underreport on the IIP-32 on certain items that may tap the three previously stated constructs. Unfortunately, the present study did not include a reliable diagnosis (*i.e.*, one that was derived from a structured clinical interview) and so this analysis is not possible.

Our study is limited by the fact that the measures used were all patient self-report questionnaires. Because of this, we are able to assess only the more explicit facets of how the patients evaluate their behavioral problems and problems in interpersonal interactions. Future research should evaluate how the SOS-10 relates to more performance-based (*i.e.*, implicit) measures, as well as observer ratings. We also compared the SOS-10 only to measures of dysfunction, and future research would do well to evaluate how the SOS-10 scores relate to established outcome measures used with adolescents. Future research should also include clinical ratings so that comparisons can be made between the patients' self-evaluation of their psychological health and well-being (*e.g.*, SOS-10) and clinicians' evaluation of similar constructs (*e.g.*, Global Assessment of Functioning), as well as observers who know the patient well outside the hospital (*i.e.*, parents rating the child's behavior using the YSR-Parent form). Currently, these data are being collected by our laboratory.

Even with these limitations, this study has several strengths. We have a large clinical sample with adequate power so that we are able to identify even small effects. We used the SOS-10 in a way in which we would hope it would be used in clinical practice, by administering it to every patient who was admitted to the floor within 1 day of his/her admission. Our sample is also very diverse, which reflects the patient population that our adolescent psychiatric inpatient unit treats.

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DISCLOSURES

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