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Abstract

Developed, piloted, and examined the psychometric properties of the Child and Adolescent Social and Adaptive Functioning Scale (CASAFS), a self-report measure designed to examine the social functioning of young people in the areas of school performance, peer relationships, family relationships, and home duties/self-care. The findings of confirmatory and exploratory factor analysis support a 4-factor solution consistent with the hypothesized domains. Fit indexes suggested that the 4-correlated factor model represented a satisfactory solution for the data, with the covariation between factors being satisfactorily explained by a single, higher order factor reflecting social and adaptive functioning in general. The internal consistency and 12-month test-retest reliability of the total scale was acceptable. A significant, negative correlation was found between the CASAFS and a measure of depressive symptoms, showing that high levels of social functioning are associated with low levels of depression. Significant differences in CASAFS total and subscale scores were found between clinically depressed adolescents and a matched sample of nonclinical controls. Adolescents who reported elevated but subclinical levels of depression also reported lower levels of social functioning in comparison to nonclinical controls.

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The Development and Psychometric Properties of a Measure of Social and Adaptive Functioning for Children and Adolescents

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Developed, piloted, and examined the psychometric properties of the Child and Adolescent Social and Adaptive Functioning Scale (CASAFS), a self-report measure designed to examine the social functioning of young people in the areas of school performance, peer relationships, family relationships, and home duties/self-care. The findings of confirmatory and exploratory factor analysis support a 4-factor solution consistent with the hypothesized domains. Fit indexes suggested that the 4-correlated factor model represented a satisfactory solution for the data, with the covariation between factors being satisfactorily explained by a single, higher order factor reflecting social and adaptive functioning in general. The internal consistency and 12-month test–retest reliability of the total scale was acceptable. A significant, negative correlation was found between the CASAFS and a measure of depressive symptoms, showing that high levels of social functioning are associated with low levels of depression. Significant differences in CASAFS total and subscale scores were found between clinically depressed adolescents and a matched sample of nonclinical controls. Adolescents who reported elevated but subclinical levels of depression also reported lower levels of social functioning in comparison to nonclinical controls.

There are many theoretical issues relating to the construct of social and adaptive functioning. Generally speaking, the construct involves a judgment (made by the self or another person) about the relative success of an individual in fulfilling the expectations of a given culture or society in various realms of life. Obvious questions arise, such as who should make the judgment of competence, in which realms of life, and according to what criteria. Despite difficulties in terminology and definition, the terms *social competence* and *adaptive* or *social functioning* are widely used in clinical practice. For the purposes of this study, these terms will be used interchangeably, with *social functioning* defined as the degree to which an individual fulfils various roles in his or her life (Weissman, 1986). Among the primary domains of social functioning relevant to most individuals are work, family relationships, relationships with extended family or friends, leisure and social activities, household duties, and self-care. The life domains of significance will vary across the lifespan, thereby making it important for the content of measures of social and adaptive functioning to be tailored to particular age groups.

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Studies with clinical samples suggest that deficits in social functioning are associated with many forms of psychological disorders, including internalizing (e.g., Puig-Antich et al., 1993) and externalizing problems (e.g., McGough, Speier, & Cantwell, 1993; Renouf, Kovacs, & Mukerji, 1997). For example, research has shown that, in general, adolescents with elevated depressive symptoms display lower levels of social functioning, including isolation from peers (Kandel & Davies, 1982); poor academic performance (Kovacs & Goldston, 1991); and poor family relationships (Kandel & Davies, 1982). The pattern of deficits in social functioning may differ according to the form of psychological disorder. For instance, depressed adolescents often withdraw from family and friends, refuse to participate in recreational activities, and find it difficult to fulfill work demands at school or home (Puig-Antich et al., 1993). In contrast, young people with schizophrenia often fail in daily self-care routines and in many instances cannot maintain steady friendships, relationships, or employment (Patterson et al., 1997; Shepherd, Watt, Falloon, & Smeeton, 1989).

There are several reasons why it is important to be able to assess the nature and extent of deficits in social and adaptive functioning. First, the diagnosis of most mental disorders requires not only the presence of specific symptoms of psychopathology, but also impairment in daily functioning. Thus, a disorder is only regarded as being present if the presenting emotional and

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