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Development and preliminary validation of the First Episode Social Functioning Scale for early psychosis

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ABSTRACT

The current study aimed at developing and conducting a preliminary validation a novel social functioning measure for people with early psychosis. The First Episode Social Functioning Scale (FESFS) was developed to cover many domains specific to this population in their contemporary reality. The self-report version of the FESFS was administered to 203 individuals receiving services in first episode clinics. Scores of the GAF, SOFAS, Social Functioning Scale and BPRS were also obtained for parts of the sample to calculate convergent and discriminant validity. A subgroup also answered the FESFS at several time points during treatment in order to determine sensibility to change. Principal component factor analyses and internal consistency analyses revealed the following nine factors with alphas ranging from 0.63 to 0.80: Friendships and social activities, Independent living skills, Interacting with people, Family, Intimacy, Relationships and social activities at work, Work abilities, Relationships and social activities at school, Educational abilities. Convergent and discriminant validity were demonstrated, as well as sensitivity to change. Clinical and research utility of the FESFS are discussed.

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1. Introduction

Social functioning includes everything needed to successfully live in today's society, such as independent living skills (cooking, cleaning, hygiene, etc.), engaging in positive relationships with family and friends (social skills), as well as abilities at school and work (Lin A. et al., 2013; Lecomte et al., 2008a). For individuals having experienced a first psychotic episode, symptomatic remission is often achieved quickly but recovery in terms of social functioning can be more difficult to achieve and might require specific psychosocial services and treatments (Álvarez-Jiménez et al., 2012). It has been reported that premorbid social functioning deficits, even during childhood, might predict difficulties in social functioning after a first episode of psychosis (Bratlien et al., 2012). Others suggest that cognitive deficits and negative symptoms are also linked to poorer social functioning (Lee et al., 2012), although

not to every domain of social functioning (Bourdeau et al., 2012). It is, however, generally accepted that social functioning is independent of positive psychotic symptoms (Lin C.H. et al., 2013). Unfortunately, one of the essential problems with studies investigating social functioning in early psychosis is the lack of adequate measures.

Surprisingly, most studies involving individuals in early psychosis use very brief measures of social functioning, most often clinician-rated, offering a single score, such as the Global Assessment of Functioning (GAF) or the Social and Occupational Functioning Assessment Scale (SOFAS). The GAF, also considered Axis V of the DSM-IV (APA, 1994), is a single score of overall last month's functioning based on the client's clinical, social and professional state. The score is based on a continuum of functioning ranging from 1 to 100 and compared to the highest score in the past year. In psychotic disorders, the score obtained is highly correlated to clinical symptoms, does not offer information pertaining to specific domains of functioning and only provides (in its most frequent use) the clinician's perspective. The SOFAS (Goldman et al., 1992) differs from the GAF in that it attempts to distinguish

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social functioning from symptom severity and considers the impact of general medical conditions. It also offers two scores, one related to the individual's level of social functioning, and one for occupational functioning, although many use a single total score, and is assessed by the clinician. Clinician reports are based on inquiries and observations, and mostly assess behaviors rather than ability, whereas many reasons can explain the absence of a behavior. A self-report questionnaire can also measure behavior but has the advantage of also accessing perceived ability or ease in social situations for instance. It is important to note that self-report and informant evaluations of functioning are typically not strongly correlated, due to limited access informants have to personal and specific behaviors occurring outside the clinical setting (Wallace et al., 2001).

Some authors report using more comprehensive self-report measures of social functioning (Bratlien et al., 2012; Lee et al., 2012) such as the Social Functioning Scale (SFS; Birchwood et al., 1990). The SFS assesses social functioning with seven subscales: Withdrawal/social engagement, Interpersonal communication, Independence–performance, Independence–competence, Recreation, Prosocial, and Employment/occupation. Each subscale has different number of items, and is rated in various ways (Likert scales, ratings from 0 to 100, yes/no answers, numeric answers (e.g. number of friends)). It covers in details many aspects of social functioning and is designed to assess change over time, although many often only report a single global score instead of presenting details from the subscales. Furthermore, it was developed in 1990 and does not take into consideration the widespread utilization of communication technologies (internet, social media friendships, or chatting over mobile phones), which are part of social functioning in today's reality of youth and young adults followed in first episode clinics. It also does not have an 'education' section whereas many individuals are still in school, college or university.

Thus, there is a need for a social functioning measure that is psychometrically solid, comprehensive, and more adapted to today's reality of individuals receiving services in first episode clinics, i.e. youth and young adults. Our team has developed a fairly brief yet comprehensive measure of social functioning, named the First Episode Social Functioning Scale (FESFS). The goal of this study is to present the development and the preliminary validation of the FESFS, i.e. construct validity, convergent and discriminant validities as well as preliminary results regarding sensitivity to change.

2. Method

2.1. Participants

A total of 203 individuals from three first episode clinics across Canada (Calgary, Vancouver, and Montreal) participated in this validation study, following informed consent. The study was approved by the University of Montreal, University of British Columbia and University of Calgary research and ethics boards. In order to take part, the participants needed to be over 18 years of age, receiving outpatient services from a participating first episode clinic, and to be able to read and write in English or French. The participants were on average 24.5 years old (S.D.=4.25, between 18 and 35), had been first diagnosed with a schizophrenia spectrum psychotic disorder on average 1.6 years earlier (S.D.=0.62), and had completed on average 12.7 years of education (S.D.= 2.7). Overall, 69% (N=140) were male, 84% (N=171) were born in Canada, 89% (N=181) were single, 44% (N=89) were living with their parents (21%, N=43 living with their partner). A majority of our sample were Caucasian (67%, N=136), with 10% (N=20) Latin American, 8% (N=16) Asian, 6% (N=12) African/Caribbean, 4% (N=8) First Nation and 5% (N=11) described their ethnic background as 'other'. A total of 62 participants (31%) mentioned working on average 29 hours/week (S.D.=12.4), whereas 22 (11%) mentioned being in an education program for an average of 21.4 hours a week (S.D.= 14.4).

2.2. Measures

The following measures were administered to either the entire sample or a subsample: A brief sociodemographic questionnaire, the First Episode Social Functioning Scale (FESFS, described below), the Social Functioning Scale (SFS; Birchwood et al., 1990, described earlier), the Global Assessment of Functioning (GAF; APA, 1994, described earlier), the Social and Occupational Functioning Assessment Scale (SOFAS; Goldman et al., 1992, also described earlier) as well as the Brief Psychiatric Rating Scale-Expanded version (BPRS; Ventura et al., 1993). The BPRS is a semi-structured interview pertaining to psychiatric symptoms conducted by trained interviewers. Only the positive and negative symptom scales are used here.

2.3. Procedure

All participants (N=203) answered the FESFS questionnaire along with socio-demographic questions. To determine convergent and discriminant validity, first a subsample (n=66) completed both the FESFS questionnaire and the Social Functioning Scale (Birchwood et al., 1990), and were interviewed with the Brief Psychiatric Rating Scale-Expanded version (Ventura et al., 1993). Secondly, a subsample of 32 participants (from the N=66) enrolled in group cognitive behavior therapy for psychosis answered the FESFS questionnaire thrice over the course of 9 months to assess sensitivity to change over time. Finally, for two other subsamples, the attending psychiatrist completed a GAF (APA, 1994) or SOFAS (Goldman et al., 1992) score (N=40 each).

2.4. Development of the FESFS

The FESFS is a comprehensive social functioning rating scale designed by three of the authors (TL, TE, MC) for both research and clinical purposes, investigating not only the ability but the frequency of the actual behaviors. The authors listed domains they believed should be included in the measure based on their experience with people with early psychosis and on reviews of existing measures of social functioning. The measure was designed to tap into multiple domains of social functioning, namely: independent living skills, interacting with people in different contexts, social activities, intimacy, friendships, family relations, work, and school. The domains were chosen to represent as much as possible the social reality of youth and young adults. The language and the examples used were also adapted to the clientele (for e.g. 'hanging out with buddies', 'chatting on the net'). For each domain, each question has two sides: A—assessing the perceived ability (e.g. *I find it easy to talk with people my age I know just a little bit*) and B—assessing the frequency of the behavior (e.g. *In the past 3 months, I have been talking to people my age I know just a little bit*). Each question, i.e. ability and behavior, is evaluated on a four-point Likert scale (from 1 = *totally disagree* to 4 = *totally agree*, or from 1 = *never* to 4 = *always*), with specific probes and examples depending on the area assessed.

The FESFS initially consisted of 42 questions (the number of questions could vary depending if the person was or not in school and/or working). We also chose the A side of the questions (ability) over the B side (frequency of behavior) for the factor analysis given that having the ability positively influences one's intention to perform a behavior, whereas many reasons, such as recent discharge from the hospital, can explain low frequency of a behavior even if the person possesses the skills.

2.5. Analyses

An exploratory factor analysis using SPSS-19 principal components analysis (PCA) with varimax rotation was performed on the FESFS questionnaire excluding the Work and Education domains (n=203), which were analyzed separately, since people either worked or went to school (rarely did both). Given that we wished for a briefer FESFS, weaker items were removed when necessary (i.e. weak saturations on all factors). Different indices were considered such as scree plot (i.e. break), eigenvalues (> 1.0), percentage of total variance (> 50%), and item loadings on each emerging dimension (> 0.30). Internal consistency calculations were then performed. In a separate exploratory factor analysis, the same procedure was followed for the Work domain since the sample size allowed us to do to it (n=124). As for the Education domain (n=57), only internal consistency analyses were performed, the number of subjects being too small to run PCA.

Scores for each factor or domain were calculated and Pearson correlations with the SOFAS, GAF, SFS and BPRS measures were computed. Paired t-tests were performed for the repeated administrations of the FESFS in a cognitive behavior therapy treatment context, in order to assess sensitivity to change over time

3. Results

3.1. PCA factors and internal consistency

The first PCA revealed results indicating a value of 7.0 for the first eigenvalue (and 1.3 for the last) and accounted for 60.9% of

the total variance. Regarding the scree plot, it was possible to observe a break after the first factor and another after the fifth factor. However, the variance was well distributed on the five factors (from 8.9% to 15.3%). Even though we noted double loading factors for three items, all others loaded significantly on their respective factor ranging from 0.40 to 0.85 (see Table 1). Also, four items were removed because they loaded poorly (< 0.30) or on more than one factor (e.g. 'money management' was linked to Family and Intimacy domains as well as Independent living skills), or had low response rates (e.g. 'good at resolving conflicts'). Most of the items aggregated together according to the anticipated domains, with the exception of the Friendship and social activities domains that ended up together instead of on two different factors. The alpha coefficients for each domain range from 0.63 (acceptable for three-item factors) to 0.80, which reflect a satisfactory internal consistency for each subscale.

As for the Work domain, the second PCA showed a value of 2.6 and 1.1 for the revealed two eigenvalues respectively and accounted for 61.8% of the variance (see Table 2). With respect to the scree plot, it was possible to observe a break after the second factor with the variance well distributed on the two factors (34.9% and 26.9% respectively). The items were loaded significantly on their respective factor (from 0.58 to 0.84) with one item having a double loading factor (see Table 2). Only one item was removed (creativity at work) because it loaded poorly on both factors (< 0.30). The two factors were named Relationships and social activities at work, and Work abilities. The final 34 item version of the FESFS with only the kept items is presented in Tables 1 and 2 (with the Education items detailed below).

Given that the work and education items were conceived to be similar in content but different in context, we only ran the internal consistency analysis for the education domain on two dimensions, dividing the more social items from the abilities items. Only one item was removed because it reduced the subscale's alpha ('meeting my educational goals'). The subscale School relationships and social activities at school had a Cronbach's alpha of 0.73 and includes the following items: *I am able to talk to my teacher/professor about things at school/college/university that matter to me (classes, assignments, schedules, etc.); The other students and I typically get along; I am comfortable participating in the classroom.* The subscale Educational abilities ($\alpha=0.74$) includes: *I am always able to finish my assignments on time; I come to the school/college/university on time and rarely miss classes; I am able to consistently get good grades.*

3.2. Convergent validity

Pearson's correlations between the FESFS and other measures of social functioning, namely the GAF, the SOFAS, and the SFS are found in Table 3. As can be seen, the GAF score is significantly correlated with the Family subscale ($r=0.43$, $p < 0.001$) and the Educational abilities subscale ($r=0.76$, $p < 0.01$), whereas the SOFAS is correlated with both the Family subscale ($r=0.55$, $p < 0.001$) and the Independent living skills subscale ($r=0.33$, $p < 0.01$), with close to significance for school and work abilities, both assessed by the SOFAS. As for the SFS, as expected, several subscales were correlated (from $r=0.26$ to $r=0.65$) with the SFS subscales (see Table 3). Only the Family, Relationships at work abilities and Educational abilities subscales were not significantly correlated with any of the SFS subscales. The negative symptoms scale of the BPRS is negatively correlated with Independent living skills, Interacting with people and Intimacy (from $r=-0.30$ to -0.36).

3.3. Discriminant validity

As anticipated, Pearson correlations revealed that positive psychotic symptoms as measured by the BPRS were not significantly correlated with any of the FESFS subscales (see Table 3).

3.4. Floor or ceiling effects

As can be seen in Table 3, the participants scored on average between 2.92 and 3.47 (minimum 1, maximum 4) on each subscale of the FESFS, with variance between 0.27 and 0.38, suggesting some variance in scores and no floor or ceiling effects. The average scores for the frequency of behaviors or B- sides of the questions were as follows (also minimum 1, maximum 4): Friendship and social activities 2.70 (S.D.=0.53), Independent living skills 3.49 (S.D.=0.46), Interaction with people 2.90 (S.D.=0.59), Intimacy 2.04 (S.D.=0.82), Family 2.84 (S.D.=0.74), Relationships and social activities at work 2.56 (S.D.=0.89), Work abilities 3.20 (S.D.=1.05), Relationships and social activities at school 2.78 (S.D.=0.86), and Educational abilities 3.26 (S.D.=0.71). Overall the variance ranged from 0.21 to 1.1, also suggesting variance in responses and no floor or ceiling effects.

3.5. Sensitivity to change

Cognitive behavior therapy for psychosis has been documented to promote change in symptoms as well as in social functioning (Addington and Lecomte, 2012), and is therefore an appropriate intervention to help determine the FESFS's sensitivity to change. Thirty-two individuals receiving group cognitive behavior therapy (see Lecomte et al., 2008b) for psychosis were assessed with the FESFS prior to starting the group, 3 months and 9 months follow-up. Mean comparisons revealed that most scores remained stable over the course of 3 months (seven out of nine), except for improvements on the Intimacy subscale ($t(28)=2.35$, $p < 0.05$) and Relationships and social activities at school subscale ($t(8)=3.98$, $p < 0.01$). At the 9 month time-point, significant improvements were found on the Intimacy subscale ($t(28)=2.81$, $p < 0.01$), the Relationships and social activities at work subscale ($t(9)=2.37$, $p < 0.05$), and trends were seen for the Independent living skills subscale ($t(29)=1.89$, $p=0.069$), and for the Friendships and social activities subscale ($t(27)=1.93$, $p=0.063$). These changes might be linked to the intervention or to other services received in the First Episode clinic, but nonetheless reflect the sensitivity of the FESFS to change over time.

4. Discussion

Our results support the preliminary validation of the FESFS, which consists of a total 34 items distributed on nine subscales assessing various domains of social functioning. Each subscale has demonstrated good internal consistency. These subscales represent nine domains that are central to social functioning of youth and young adults. *The Friendship and social activities* subscale taps into close relationships, buddies and how one manages one's own leisure time. We intentionally ask about meaningful activities the person engages in, rather than harmful activities (such as abusing substances), to keep the instrument mostly focused on positive aspects, such as abilities, interests, comfort or useful behaviors. *The Independent living skills* subscale measures specific abilities related to self-care, and to getting around, including using the internet or phone to communicate; these are all essential to living autonomously in the community. *The Interacting with people* subscale reflects social skills needed to interact with people in different settings. It also includes polite assertiveness, which is part of a

Table 1
Factor structure of the FESFS—Social and Independent living skills dimensions (N=203).

Dimensions and items from FESFS	Factors				
	1	2	3	4	5
Friends and activities (n=6 items; α=0.80)					
I have friends that I can hang out with, do stuff with (shopping, movies, go out...).	0.70				
I try to do things that are really important to me (specific hobbies, passions...).	0.69				
I feel I have at least one best friend with whom I can share important things that happen to me.	0.67				
I am able to balance the amount of time I spend with others and by myself.	0.67				
I am able to make new friends by suggesting getting together, making invitations or phoning people up.	0.53				
I am really good in solo activities such as going to the gym, going to the movies, chatting on the net, taking lessons (music, painting, etc).	0.49		0.43		
<i>Please do not count watching TV, listening to music or playing videogames.</i>					
Independent living skills (n=4 items; α=0.81)					
I can get around town easily, either by taking the bus or by other means of transportation.		0.85			
I am good at taking care of my physical appearance and hygiene.		0.76			
I have no problem getting enough food to eat (by cooking, family, fast food, etc.).		0.72			
I am comfortable using the phone, internet or email to communicate.		0.62			
Interacting with people (n=4 items; α=0.80)					
I find it easy to talk with people my age I know just a little bit.			0.82		
I know how to stand up for myself when needed.			0.75		
I find it easy to interact with waiters, cashiers, and salespeople (e.g. small talk, asking for information, making a purchase).			0.67		
I find it easy to interact with authority figures (e.g. teacher, boss, doctor, others' parents...).			0.46		
Intimacy (n=5 items; α=0.75)					
I am interested in sex.				0.75	
I enjoy having a stable boy/girlfriend or spouse.	0.45			0.75	
I feel I am able to share feelings, inner thoughts, and be close with my stable boy/girlfriend or spouse (when I have one).				0.59	
I am quite comfortable dating.	0.43			0.54	
I can quickly understand what is going on in most situations involving other people.				0.40	
Family (n=3 items; α=0.63)					
My parents and I typically get along.					0.82
I can talk to my parents about things that matter to me.					0.64
I get along well with my family (siblings, grandparents, uncles, aunts, cousins).					0.63
Eigenvalues	7.0	1.9	1.7	1.6	1.3
Variance after rotation	15.3	12.8	12.7	11.2	8.9

Table 2
Factor structure of the FESFS—work dimensions (N= 124).

Dimensions and items from FESFS	Factors	
	1	2
Relationships and social activities at work (n=3 items; α=0.67)		
I typically get along with my co-workers.	0.80	
I usually feel comfortable discussing issues related to work with my supervisor (e.g. tasks, feedback, schedules, etc.)	0.77	
I participate in social activities on the job (Christmas party, afterwork outings, etc).	0.68	
Work abilities (n=3 items; α=0.65)		
I do my work tasks within the expected time-frame		0.84
I always respect my work schedule (get to work on time and leave on time).		0.72
I consistently provide a good quality of work	0.53	0.58
Eigenvalues	2.6	1.1
Variance after rotation	34.9	26.9

healthy self-esteem and a difficult skill for many to master (Borras et al., 2009). *The Family* subscale addresses aspects of the relationship with the person's parents, as well as with other family members. Given the importance of family members in the treatment of people following a first psychotic episode (Thewissen et al., 2008), this subscale is quite relevant. *The Intimacy* subscale is a novelty, in that other than asking if someone has a partner, most social functioning instruments do not inquire about abilities in dating, interest for sex, ability to grasp interpersonal situations, or interest for having a stable intimate relationship. As for the work and education subscales, it is not surprising that the interpersonal items aggregated together and the abilities also were grouped together, given that one's success at school or at work is not solely

linked to one's performance but also to how the person manages to get socially integrated (Banks et al., 2001).

Our results further emphasize the importance of measuring various domains of social functioning rather than using a global score (Bourdeau et al., 2012; Smith et al., 2011). In terms of convergent validity with clinician rated GAF and SOFAS scores, they only correlated with some of the subscales. This result is not surprising given that self-reports and other reports are often different, though somewhat correlated (Lecomte et al., 2004). At least three FESFS subscales correlated negatively with negative symptoms, following what was expected from the literature (Lee et al., 2012). As for the more comprehensive SFS, the FESFS did correlate with most of its subscales, supporting its convergent

Table 3
Pearson correlations between FESFS scales, GAF, SOFA, SFS and BPRS.

Measures	Mean	S.D.	1	2	3	4	5	6	7	8	9
1. FESFS—Friendships/social activities (n=203)	2.94	0.54	–	0.49**	0.55**	0.54**	0.24**	0.55**	0.34**	0.74**	0.48**
2. FESFS—Independent living skills	3.47	0.52		–	0.52**	0.44**	0.23**	0.42**	0.19*	0.53**	0.29*
3. FESFS—Interacting with people	3.07	0.56			–	0.47**	0.26**	0.51**	0.26**	0.55**	0.43**
4. FESFS—Intimacy	2.91	0.57				–	0.19**	0.39**	0.19*	0.61**	0.38**
5. FESFS—Family	3.21	0.78					–	0.21*	0.25**	0.06	–0.04
6. FESFS—Relationships and social act. at work	2.93	0.54						–	0.45**	0.65**	0.55**
7. FESFS—Work abilities	3.11	0.52							–	0.51**	0.55**
8. FESFS—Relationships and social act. at school	3.04	0.55								–	0.61**
9. FESFS—Educational abilities	3.01	0.60									–
10. SOFAS (n=40)	56.9	12.9	0.09	0.33*	0.17	0.26	0.55**	–0.19	–0.29	–0.38	–0.43
11. GAF (n=40)	53.3	13.3	0.03	0.24	0.12	0.09	0.43**	–0.22	–0.35	0.54	0.76*
12. SFS withdrawal/engagement (n=66)	7.74	2.18	0.24	0.31*	0.06	0.35**	0.05	–0.14	–0.16	–0.10	0.15
13. SFS Interpersonal communication	6.94	3.85	0.34*	0.13	0.19	0.29*	0.12	0.31	0.16	0.23	0.06
14. SFS Independence/Performance	15.5	5.0	0.38*	0.28*	0.26*	0.26*	–0.17	0.33	0.35*	0.65*	0.37
15. SFS Recreation	7.9	3.2	0.29*	0.06	–0.02	–0.02	–0.21	0.09	–0.06	0.55*	–0.14
16. SFS Prosocial	7.1	4.9	0.42*	0.16	0.17	0.17	–0.10	–0.10	–0.08	0.23	–0.10
17. SFS Independence/Competence	14.2	3.4	–0.13	–0.30*	–0.20	0.27*	0.06	–0.29	–0.22	–0.33	–0.003
18. SFS Occupation/Employment	4.6	3.1	0.37*	0.34*	0.34*	0.45*	0.02	0.04	0.29	0.37	0.48
19. BPRS positive scale (n=66)	25.8	5.7	–0.19	0.00	–0.15	–0.11	–0.17	–0.16	–0.20	–0.21	–0.22
20. BPRS negative scale (N=66)	8.14	3.5	–0.26	–0.34*	–0.36*	–0.30*	–0.05	–0.13	–0.05	–0.31	–0.38

* $p < 0.01$.

** $p < 0.001$.

validity, although perhaps not as straightforwardly as expected. A closer look at the SFS subscales enabled us to see that the concepts measured in the SFS and FESFS subscales were in fact quite different. For instance, the SFS Independence/Performance subscale includes items related to hygiene, to shopping, and to looking for work. It is therefore not surprising that it is correlated with the Independent living skills (hygiene), Friendship and social activities (solo activities), and Work abilities subscales of the FESFS. Another example is the SFS Occupation/Employment subscale: it rates the number of hours worked and the type of work or occupation the person has whereas the FESFS subscale Work abilities focus on punctuality, productivity and quality of work delivered. The correlation of 0.29 is therefore understandable. FESFS subscales measuring concepts not present in the SFS (school performance for instance) did not correlate with any SFS subscales, further supporting the validity and the originality of the FESFS. Of import, a higher percentage of participants preferred to have the SFS delivered as an interview instead of self-report, compared to the FESFS (95% vs 41%); this might have also influenced the results. As for discriminant validity, it was demonstrated by the absence of links between the BPRS positive psychotic symptoms subscale and all of the FESFS subscales, as suggested in the literature (Lin et al., 2013).

Our results demonstrated that the FESFS is mostly stable over short periods but is sensitive to change over time, and that the scores on the subscales do not all change together. Indeed, the participants who received group cognitive behavior therapy for psychosis improved in some domains that might have been facilitated by the group process (i.e. intimacy, social aspects of school or work, friendships) but not others, such as family relations, which tend to be more stable unless specifically targeted by an intervention.

Our study has some limitations. First, the sample only included individuals over 18, whereas the measure was developed for youth and young adults. Second, the subscales related to work and education need to be further validated with a larger sample, given only a small part of our sample were working or studying. Furthermore, only some aspects of validity have been explored here. Future studies investigative test–retest reliability as well as confirming the factorial structure and the preliminary validity results found here are warranted. Finally, our results support the

factor structure of the ‘ability’ side of the FESFS questions only. We do recommend using both sides of the questions (calculated separately) especially for clinical purposes, since together they offer a more complete picture of the person’s social functioning. For instance, someone might be highly capable of socializing, but is currently isolating himself to write a book; other measures focusing only on performance or typical behaviors would rate this person as functioning poorly. The FESFS could also be administered as an informant version, with a potential for clinical relevance in helping instigate discussions around discrepancies between versions with people who are less verbal (Lecomte et al., 2004); the informant version has not yet been validated.

5. Conclusion

We believe the First Episode Social Functioning Scale is a much needed instrument in early psychosis research and treatment. More studies are warranted in order to confirm the factors and results reported here, and with younger individuals as well. The measure is available upon request from the first author.

The authors have declared that there are no conflicts of interest in relation to the subject of this study.

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