

Social Adjustment Scale Self-Report (SAS-SR)

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Synonyms

SAS-SR; SAS-SR: Screener; SAS-SR: Short

Definition

Self-report measures of instrumental and expressive role performance at work, in social activities, and with family (including extended family, marital partners, parental roles, and family unit) include a 54-item full-length version, a 24-item short version, and a 14-item screening version.

Description

The Social Adjustment Scale Self-Report (SAS-SR; Weissman 1999) is a paper-and-pencil self-report scale that measures instrumental and expressive role performance over the past 2 weeks in adults. The 54-item assessment covers six areas of functioning, including work (either as a paid worker, unpaid homemaker, or student), social and leisure activities, relationships with extended family, role as a marital partner (if applicable), parental role (if applicable), and role within the family unit (including perceptions of economic functioning). The items within each of the six areas cover four types of content, including performance at expected tasks, the amount of friction with people, finer aspects of interpersonal relationships, as well as feelings and satisfactions.

In addition to the full-length SAS-SR, abbreviated versions of the scale are also available: the 24-item Social Adjustment Scale Self-Report:

Short and the 14-item Social Adjustment Scale Self-Report: Screener (SAS-SR: Short and SAS-SR: Screener, Weissman 2007). These abbreviated versions were developed for use in client screening, test batteries, and other research programs where the reduction of participant burden (i.e., time to complete the assessment) is important.

Administration requires approximately 15–20 min for the full-length SAS-SR, 10 min for the SAS-SR: Short, and 5 min for the SAS-SR: Screener. Raw scores are converted to gender-based standard scores (including *T*-scores and percentiles), with higher scores indicating higher levels of impairment (i.e., lower levels of social adjustment).

The SAS-SR normative sample consists of ratings from 482 adults (205 men, 277 women), aged 25–70 years. The normative sample for the SAS-SR: Short and SAS-SR: Screener consists of ratings from 957 adults (422 male, 535 female), aged 18–87 years.

Development

The full-length SAS-SR is based on the SAS-Interview, an interview that was originally developed for use in the treatment of depressed patients. The SAS-Interview was developed based on reviews of the literature and existing social adjustment scales. The interviews were conducted over 6 months in a series of studies with different groups of psychiatric patients. The SAS-SR was derived directly from the SAS-Interview by transforming the interview questions into a self-report format on a 5-point scale. The revised wording was tested on a pilot sample of 76 depressed outpatients (Weissman and Bothwell 1976).

The SAS-SR: Short and SAS-SR: Screener were developed through a series of reliability, content, and confirmatory factor analyses that were conducted on data from 957 nonclinical participants who were assessed with the full-length SAS-SR via a postal survey. In determining which items to retain on the shortened versions, item-level reliability analyses were conducted in a backward stepwise manner with the worst items being removed one at a time until the items were finalized. Content analyses were conducted in

tandem with the reliability analyses in order to ensure that the theory underlying the full-length assessment was maintained. The content analyses involved ensuring that all six role areas and all four content areas were represented on the shortened scales (Weissman 2007; see also Gameroff et al. 2012).

Reliability

Internal Consistency

Edwards, Yarvis, Mueller, Zingale, and Wagman (1978) found acceptable internal consistency (Cronbach's alpha = .74) in sample of 92 individuals who completed the SAS-SR. Weissman (2007) sampled 957 individuals and found very strong levels of internal consistency for the SAS-SR: Short (Cronbach's alpha = .88) and the SAS-SR: Screener (Cronbach's alpha = .80). These results are particularly impressive given that Cronbach's alpha will likely underestimate the reliability of instruments like the SAS-SR where item branching allows respondents to skip questions (Edwards et al. 1978).

Test-Retest

Edwards et al. (1978) had a sample of 92 raters complete the SAS-SR on three separate occasions spaced 2 weeks apart. Test-retest reliability was strong for the SAS-SR, with $r = .72$ for time 1 to time 2 and $r = .82$ for time 2 to time 3. Weissman (2007) found acceptable test-retest reliability levels for the SAS-SR: Short ($r = .64$) and the SAS-SR: Screener ($r = .63$) from a sample of 35 adults who completed the assessments twice over a 1- to 3-week interval.

Validity

Validity evidence for the SAS-SR has been published in nearly 200 research articles with several population types across multiple domains including affective disorders, eating disorder, substance abuse disorders, well-being in the elderly, marital satisfaction and divorce, gender issues, pharmacotherapy, physical disorders, psychotherapy, reproductive issues, parenting, suicide, trauma, as well as treatment and treatment

follow-up. The following section represents a small selection of these studies.

Convergent Validity

Weissman, Olfson, Gameroff, Feder, and Fuentes (2001) assessed a sample of 211 primary care patients with the SAS-SR, the Social Adaptation Self-Evaluation Scale (Bosc and Polin 1997), and the Medical Outcomes Study 36-item Short-Form Health Survey (Ware et al. 1994). Correlations among the scales were statistically significant, with the SAS-SR overall adjustment score correlated at $r = .57$ ($p < .001$) with the total score from the Social Adaptation Self-Evaluation Scale and at $r = .62$ ($p < .001$) with the mental component score from the Short-Form Health Survey.

Treatment Sensitivity

Kocsis, Frances, Voss, and Mason (1988) assessed the effect of imipramine treatment in 76 patients with a diagnosis of major depressive disorder. Patients were assigned to an imipramine group or to a placebo group. Patients who were assigned to the imipramine group but failed to complete the trial were placed in a non-completers group. After 6 weeks of treatment, no change in SAS-SR scores were observed for the placebo or non-completers groups, while scores dropped significantly in the imipramine group ($p < .01$).

Discriminative Validity

Weissman, Prusoff, Thompson, Harding, and Myers (1978) reported that SAS-SR scores could distinguish between participant groups. Specifically, they found that both the overall adjustment score and the role-area subscales were able to distinguish between four groups (community sample [$N = 482$], acute depressives [$N = 191$], alcoholics [$N = 54$], schizophrenics [$N = 47$]) in the expected direction (i.e., community < schizophrenic < alcoholic < depressed). These results indicate that the depressed sample had the lowest levels of social adjustment, while the community sample had the highest level of social adjustment.

Data from a community sample ($N = 92$; Edwards et al. 1978) were compared to data

Social Adjustment Scale Self-Report (SAS-SR), Table 1 Effect of clinical status on SAS-SR: Short and SAS-SR: Screener scores. (Adapted with permission from MHS Inc. (2007))

| Version | Role area | | Clinical group | Community group | Partial η^2 |
|-------------------------|-----------------------|-----------|----------------|-----------------|------------------|
| SAS-SR: Short | Overall | <i>M</i> | 2.26 | 1.81 | .25 |
| | | <i>SD</i> | 0.26 | 0.52 | |
| | Work role | <i>M</i> | 2.03 | 1.29 | .65 |
| | | <i>SD</i> | 0.10 | 0.36 | |
| | Social and leisure | <i>M</i> | 2.48 | 1.97 | .19 |
| | | <i>SD</i> | 0.41 | 0.60 | |
| | Extended family | <i>M</i> | 2.45 | 1.94 | .11 |
| | | <i>SD</i> | 0.62 | 0.89 | |
| | Primary relationships | <i>M</i> | 2.38 | 2.03 | .10 |
| | | <i>SD</i> | 0.39 | 0.86 | |
| | Parental | <i>M</i> | 2.09 | 1.51 | .38 |
| | | <i>SD</i> | 0.17 | 0.41 | |
| | Family unit | <i>M</i> | 2.26 | 2.11 | .02 |
| | | <i>SD</i> | 0.33 | 1.04 | |
| SAS-SR: Screener | Overall | <i>M</i> | 2.22 | 1.74 | .25 |
| | | <i>SD</i> | 0.28 | 0.56 | |

from a clinical sample ($N = 76$; Weissman and Bothwell 1976). Results revealed that for the overall adjustment score, clinical means ($M = 2.48$, $SD = 0.43$) were significantly higher ($p < .001$) than the means from the community sample ($M = 1.67$, $SD = 0.29$) providing evidence for the discriminating power of the SAS-SR.

Daniels (1986) assessed four groups of African-American men ($N = 90$). Groupings were based on education and employment status: super-achievers, average, underemployed, and unemployed. Results for the work-role scale were in the expected direction (i.e., super-achievers < average < underemployed < unemployed) indicating that the unemployed men had the lowest level of adjustment in work role while the super-achievers had the highest level of adjustment in work role.

Weissman (2007) compared SAS-SR: Short and SAS-SR: Screener scores from a sample of 70 individuals (31 men, 29 women) with a clinical diagnosis (i.e., a mood, anxiety, or substance abuse disorder) to scores from a matched sample from the community. Results provided strong evidence for the discriminative validity of the SAS-SR: Short and SAS-SR: Screener (see Table 1). The

clinical groups scored significantly higher on the overall adjustment score for both abbreviated measures with large effect sizes (partial $\eta^2 = .25$ for both versions). Similarly, moderate to large effect sizes (partial $\eta^2 = .10-.65$) were found for all of the role areas, with the exception of family unit, where a small effect was found (partial $\eta^2 = .02$).

Translations

The SAS-SR has been translated into the following languages: Afrikaans, Cantonese, Czech, Danish, Dutch, English, Finnish, French (European), German, Greek, Hebrew, Hungarian, Italian, Mandarin, Norwegian, Portuguese, Russian, Spanish (European), Spanish (South American), and Swedish.

Cross-References

- ▶ [Convergent Validity](#)
- ▶ [Cronbach's Alpha](#)
- ▶ [Discriminant Validity](#)
- ▶ [Internal Consistency](#)
- ▶ [Quality of Life](#)
- ▶ [Reliability](#)

- ▶ [Test-Retest Reliability](#)
- ▶ [Translation Research](#)

References

- Bosc, M., & Polin, V. (1997). Development and validation of a social functioning scale, the social adaptation self-evaluation scale. *European Neuropsychopharmacology*, *7*, 57–70.
- Daniels, S. (1986). Relationship of employment status to mental health and family variables in black men from single-parent families. *Journal of Applied Psychology*, *71*(3), 386–391.
- Edwards, D. W., Yarvis, R. M., Mueller, D., Zingale, D. P., & Wagman, W. J. (1978). Test-taking and the stability of adjustment scales. *Evaluation Quarterly*, *2*, 275–290.
- Gameroff, M. J., Wickramaratne, P., & Weissman, M. M. (2012). Testing the short and screener versions of the social adjustment scale-self-report (SAS-SR). *International Journal of Methods in Psychiatric Research*, *21*(1), 52–65.
- Kocsis, J. H., Frances, A. J., Voss, C., & Mason, B. J. (1988). Imipramine and social-vocational adjustment in chronic depression. *The American Journal of Psychiatry*, *145*(8), 997–999.
- Ware, J. E., Kosinski, M., & Keller, S. D. (1994). *SF-36 physical and mental health summary scales: A user's manual*. Boston: Health Assessment Laboratory.
- Weissman, M. M. (1999). *Social adjustment scale – Self-report technical manual*. Toronto: Multi-Health Systems.
- Weissman, M. M. (2007). *Social adjustment scale – Self-report: Short & social adjustment scale – Self-report: Screener technical manual*. Toronto: Multi-Health Systems.
- Weissman, M. M., & Bothwell, S. (1976). The assessment of social adjustment by patient self-report. *Archives of General Psychiatry*, *33*, 1111–1115.
- Weissman, M. M., Prusoff, B. A., Thompson, W. D., Harding, P. S., & Myers, J. K. (1978). Social adjustment by self-report in a community sample and in psychiatric outpatients. *The Journal of Nervous and Mental Disease*, *166*, 317–326.
- Weissman, M. M., Olfson, M., Gameroff, M. J., Feder, A., & Fuentes, M. (2001). A comparison of three scales for assessing social functioning in primary-care. *The American Journal of Psychiatry*, *158*, 460–466.

Social Approach Motives

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Social Attachment

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Definition

Life in society places every human being from birth in a relationship of interdependence with others, and solidarity constitutes, at all stages of socialization, the foundation of what we might call *homo-sociologicus*. The human being is inevitably linked to others and to society, not only to ensure his protection against the hazards of life, but also to satisfy his vital need for recognition, source of his identity, and his human existence. However, modern societies do not cease to defend the values of individualism, to claim for each one the right to autonomy, to impose the duty of responsibility toward oneself – which amounts to rejecting any form of dependence toward others and social institutions. This apparent contradiction has been at the heart of sociological questioning for as long as the discipline has existed. The founders of sociology – Émile Durkheim, Ferdinand Tönnies, Georg Simmel, and Max Weber – have all tried to resolve it. In 1893, Durkheim formulated the central question of his doctoral dissertation on the division of labor as follows: “Why does the individual, while becoming more autonomous, depend more upon society?” (Durkheim [1893], 2007: XLIII). (Translated by the author) In other words, is a society composed of increasingly differentiated and autonomous individuals still really a society, and if so, how? The question therefore comes down to investigating, despite the apparent autonomy that characterizes us, by what bonds we are attached to each other and to society.

The concept of *attachment* is known as a theory of psychiatry. It was developed by the psychiatrist John Bowlby (1969, 1973, 1980) in the second half of the twentieth century to describe the lasting imprint of the child's original bond to the adult in charge of providing security from the