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THE MOS SOCIAL SUPPORT SURVEY

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Abstract: This paper describes the development and evaluation of a brief, multidimensional, self-administered, social support survey that was developed for patients in the Medical Outcomes Study (MOS), a two-year study of patients with chronic conditions. This survey was designed to be comprehensive in terms of recent thinking about the various dimensions of social support. In addition, it was designed to be distinct from other related measures. We present a summary of the major conceptual issues considered when choosing items for the social support battery, describe the items, and present findings based on data from 2987 patients (ages 18 and older).

Multitrait scaling analyses supported the dimensionality of four functional support scales (emotional/informational, tangible, affectionate, and positive social interaction) and the construction of an overall functional social support index. These support measures are distinct from structural measures of social support and from related health measures. They are reliable (all Alphas >0.91), and are fairly stable over time. Selected construct validity hypotheses were supported.

INTRODUCTION

The importance of interpersonal relationships to our lives has become increasingly clear. Both seeking and receiving help from other people is a major form of coping activity. The availability of someone to provide help or emotional support may protect individuals from some of the negative consequences of major illness or stressful situations . Interest in the concept of social support has increased dramatically over the last few years due to the belief that the availability of support may impact favorably on a person's health and emotional well-being. Although we don't know yet how support improves health, there is some empirical evidence that has established its beneficial effects. For those trying to understand the etiology and course of chronic diseases, social support must be considered as an important factor that may affect a patient's functioning and well-being. The challenge is to determine how social support contributes to health. One approach to this issue is to break social support into its component parts and evaluate how different dimensions of social support relate to a variety of health outcomes.

Methods used to assess social support are quite varied due to different definitions of social support and to the lack of a clear conceptualization of the concept. In recent years, however, investigators have attempted to measure the functional components of social support under the belief that the most essential aspect of social support is the perceived availability of functional support. Functional support refers to the degree to which interpersonal relationships serve particular functions. The functions most often cited are (I) emotional support which involves caring, love and empathy, (2) instrumental support (referred to by many as tangible support), (3) information, guidance or feedback that can provide a solution to a problem, (4) appraisal support which involves information relevant to self-evaluation and, (5) social companion- ship, which involves spending time with others in leisure and recreational activities.

A second approach to social support measurement has focused on the structure of interpersonal relation-ships. Structure refers to the existence and quantity of social relationships (e.g. marital status, group membership, the number of friends one has), and the interconnectedness of a person's social relationships or social network (e.g. the degree to which a person's friends know each other). This type of social support is most frequently measured in terms of the existence of or contact with potentially supportive persons. One problem with this approach is that contact may be due to factors uncorrelated with support, such as need for contact or how busy a person is with work or other activities.

In spite of the numerous scales and questionnaires that purport to measure functional and structural aspects of social support, recent reviews of published social support measures have concluded that the psychometric properties for the majority of measures have not been convincingly documented. Not only do they differ in terms of length, focus, approach and the types of support that are evaluated, evidence for reliability and validity is often based on information from select samples, i.e. college students; multidimensional measures are, in some cases, represented by single items, which are less reliable than multi-item scales [; and the length of many inventories may be burdensome for chronically ill patients [18]. There appears to be agreement on the need for psychometrically tested instruments that are multidimensional, applicable to patient populations (who may have greater than average needs for various forms of social support), yet brief enough to minimize respondent burden.

This paper describes the development and evaluation of a brief, self-administered, multidimensional, social support survey that was developed for patients:

in the Medical Outcomes Study (MOS), a two-year longitudinal study of the process and outcomes of care for patients with prevalent and treatable chronic conditions. In addition, we provide evidence related to the dimensionality of the MOS social support survey, i.e. the extent to which the various functions of support are empirically distinct.

METHODS
Study population and data collection

The data are from patients participating in the Medical Outcomes Study (MOS), an observational study of variations in physician practice styles and patient outcomes in one of three different systems of care: health maintenance organizations (HMOs), large multispeciality groups (LMSGs), and solo fee- for-service practice. The sampling design was a staged process involving first selecting sites, then settings within sites, clinicians within settings, and patients from the practices of those clinicians (see Rogers, McGlynn, Berry, *eta/.*, for a detailed description of sampling methods and population characteristics). Briefly, three study sites (Boston, Chicago, Los Angeles) were chosen from Standard Metropolitan Statistical Areas with mature forms of each system of care. Within each system of care a representative sample of physicians (general internists, family physicians, cardiologists, endocrinologists, diabetologists, psychiatrists), psychologists, and other mental health providers were selected. All eligible physicians associated with the HMOs and LMSGs were asked to participate in the study (85% were enrolled; $N = 226$). In the solo fee-for-service sector, clinicians were initially selected by stratified random sampling from lists provided by national professional associations $(N = 2219)$. Of these. 69% were contacted.

Telephone interviews identified 513 eligible physicians (e.g. were between the ages of 31 and 55 years; were board eligible/certified or licensed for independent practice: and had direct patient care as their primary professional activity) who agreed to a final selection interview. Of these 298 (58%) participated in the main study. Among participating providers, a representative cross-section of their patients was screened during an average 9- day period. The sampling frame was the log of all patients scheduled to visit the provider during each day of screening. Excluded were patients who were under age 18. did not speak English, or were physically impaired in a way that would prohibit completing forms (e.g. blind). Patients screened $(N = 21,481)$ who appeared to have one or more of four chronic diseases (hypertension. diabetes, coronary heart disease and depression) constituted the sampling frame for the longitudinal patient panel ($N = 8040$). Hypertensives were eligible based on systolic and diastolic blood pressure readings reported by physicians; cornary heart disease patients consisted of those who had suffered a myocardial infarction within 12 months before screening and/or had congestive heart failure; diabetics were selected on the basis of physician reports of current diabetes, age of onset, and complications; depressed patients were sampled in a two-stage screening procedure. A telephone interview was then used to collect additional information, and ask eligible patients to enroll in the longitudinal panel.

The final enrolled sample included those patients who agreed to enroll in the study and completed the initial patient assessment questionnaire, a physical health examination and a calendar diary ($N = 2349$). These requirements were occasionally relaxed to maintain adequate sample size in each tracer condition. Patients who enrolled in the MOS were younger, better educated, had a higher income, and were more likely to be married or employed than were patients who refused enrollment.

The information included in this paper is based on a sample of 2987 patients who had completed the enrollment self-report questionnaire at the time these analyses were conducted. This sample is larger than the final enrolled sample because it includes data from patients who completed the patient assessment questionnaire but did not satisfy other enrollment requirements (e.g. completion of the health exam). For purposes of scaling analyses, we wanted as much data as possible. For our sample, ages ranged from 18-98 (mean age was 55). Thirty-nine percent weremale, 20% were nonwhite, 68% were married, and 46% had completed high school (average of 13.3 years of education).

Social support items

At the time our survey was developed (during 1985), we conducted a review of available support measures, focusing primarily on functional aspects of support. We decided to focus on the measurement of the perceived availability of functional support (if needed) as recommended by Cohen and Syme, Cohen and Wills, and House and Kahn because of our belief that a person's perceptions about available support are most import- ant. The fact that a person does not receive support during a given time period does not mean that the person is unsupported. Received support is confounded with need and may not accurately reflect the amount of support that is available to a person.

We generated a pool of 50 possible items based on support items and dimensions identified in the literature review. The selection of the pool of items was guided by a strong *a priori* conceptual framework regarding the important dimensions of functional support, dimensions that are common in most recent models of support. We restricted our items to perceptions of the availability of different functional aspects of support (e.g. the degree to which interpersonal relationships serve particular functions) rather than more objective structural measures of support due to limited measurement resources. We included measurement of multiple support functions so that we would be able to evaluate how different types of support relate to health outcomes. The items were designed to be as comprehensive as possible in terms of recent thinking about the various dimensions of social support, yet short enough to reduce respondent burden. In addition, they were designed to be as distinct as possible from related measures of loneliness, mental health, family functioning and social activity limitations.

We reworded items and response categories to conform to our emphasis on measuring availability of types of support. As a test of the items' face validity, six behavioral scientists were asked to designate the appropriate social support category for each of the items. This step allowed us to delete items that seemed to be difficult to categorize. A pilot study was then conducted in which the final set of 37 functional support items (along with validity variables) were administered to patients visiting a rural health clinic in Southern Illinois. Based on pilot study results, we eliminated items that were not internally consistent with their hypothesized support dimension and that did not discriminate social sup- port from other dimensions of health and health- related behavior.

Our final social support battery, then, contained 19 functional support items hypothesized to measure five dimensions of social support: (1) emotional support (the expression of positive affect, empathetic understanding, and the encouragement of expressions of feelings), (2) informational support (the offering of advice, information, guidance or feedback), (3) tangible support (the provision of material aid or behavioral assistance), (4) positive social interaction(the availability of other persons to do fun things with you), and (5) affectionate support (involving expressions of love and affection). Affectionate support has not been emphasized in the literature as a distinct type of support, but we felt that this type of support would be very beneficial to health out- comes of the chronically ill. To decrease respondent burden, we measured the various types of support without regard to the source (e.g. whether the support came from family, friends, community or others). For each item, patients were asked to indicate how often each kind of support was available to them if they needed it. Response choices were: none of the time, a little of the time, some of the time, most of the time, and all of the time.

The MOS Social Support Index
Measures functional support and is derived from a 19-item, multidimensional, self-administered survey. Results of multi-trait scaling analysis supported an overall index based on 19 items and 4 functional support subscales: emotional/informational support (8 items); tangible support (4 items); affectionate support (3 items); and positive social interaction (3 items). Each item is rated on a five-point scale ranging from "none of the time" to "all of the time", with a high subscale and/or overall score indicating a high level of social support. The tool has demonstrated validity in chronically ill patients.

The index was developed among 2 987 patients aged 18 to 98 years, with common, treatable chronic conditions (hypertension, diabetes, coronary heart disease and depression).

THE Medical Outcomes Survey (MOS) SOCIAL SUPPORT SURVEY

People sometime s look to others for companionship, assistance, or other types of support. How often is e ach of the following kinds of support available to you if you need it?
Circle one number on each line .

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional/informational support					
Someone you can count on to listen to you when you need to talk	1	2	3	4	5
Someone to give you information to help you understand a situation	1	2	3	4	5
Someone to give you good advice about a crisis	1	2	3	4	5
Someone to confide in or talk to about yourself or your problems	1	2	3	4	5
Someone whose advice you really want	1	2	3	4	5
Someone to share your most private worries and fears with	1	2	3	4	5
Someone to turn to for suggestions about how to deal with a personal problem	1	2	3	4	5
Someone who understands your problems	1	2	3	4	5
Tangible support					

This is the end of the sample version of the MOS-SSS test. To access full complete 19 item question/test criteria, plus complete MOS-SSS Validity, reliability analysis, please go to page 1 top page to purchase.