

The Multidimensional Scale of Perceived Social Support

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The development of a self-report measure of subjectively assessed social support, the Multidimensional Scale of Perceived Social Support (MSPSS), is described. Subjects included 136 female and 139 male university undergraduates. Three subscales, each addressing a different source of support, were identified and found to have strong factorial validity: (a) Family, (b) Friends, and (c) Significant Other. In addition, the research demonstrated that the MSPSS has good internal and test-retest reliability as well as moderate construct validity. As predicted, high levels of perceived social support were associated with low levels of depression and anxiety symptomatology as measured by the Hopkins Symptom Checklist. Gender differences with respect to the MSPSS are also presented. The value of the MSPSS as a research instrument is discussed, along with implications for future research.

Since the mid-1970s, there has been increasing interest in the role of social support as a coping resource. A number of researchers have demonstrated that the adequacy of social support is directly related to the reported severity of psychological and physical symptoms and/or acts as a buffer between stressful life events and symptoms (Andrews, Tennant, Hewson, & Vaillant, 1978; Barrera, 1981; Brandt & Weinert, 1981; Gore, 1978; Lin, Simeone, Ensel, & Kuo, 1979; Monroe, Imhoff, Wise, & Harris, 1983; Procidano & Heller, 1983; Sarason, Levine, Basham, & Sarason, 1983; Sarason, Sarason, Potter, & Antoni, 1985; Schaefer, Coyne, & Lazarus, 1981; Wilcox, 1981). However, a number of questions remain. A primary difficulty is related to how best to define

social support. Although all writers in this area agree that it involves some kind of relationship transaction between individuals, the nature of the transaction is specified in a variety of ways. Shumaker and Brownell (1984), for instance, characterized social support as "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient" (p. 13). On the other hand, Cohen and Syme (1985) stated that the resources provided by others can have either a negative or positive effect. Focusing on the subjective-objective dimension, Lin (1986) defined social support as "perceived or actual instrumental and/or expressive provisions supplied by the community, social networks, and confiding partners" (p. 18). In a useful breakdown of five key dimensions, Tardy (1985) suggested that the best way to clarify differences in definition and approach to social support is to specify direction (support can be given and/or received), disposition (availability vs. utilization of support resources), description of support versus evaluation of satisfaction with support, content (what form does the support take?), and network (what social system or systems provide the support?).

Another related issue concerns the question of how social support operates. Some important hypotheses and dimensions with respect to this issue have been explored, including: (a) direct effect versus buffering, (b) the nature of the support, (c) the focus of the curative effect of support, and (d) the action by which social supports operate to enhance health. In terms of the first issue, there is some evidence to support the hypothesis that support may produce helpful effects directly, regardless of the level of stress or disruption in a person's life (Broadhead et al., 1983). However, others have argued that social support acts primarily as a buffer, protecting individuals from the harmful effects of stress (Cohen & McKay, 1984; Gore, 1981; House, 1981). It may be that both hypotheses have validity. That is, although social support may be directly helpful in all circumstances, it may be particularly effective as a buffer during times of stress.

With respect to the second issue, the nature of the support, a variety of theories have been proposed. Thoits (1986) suggested that social support operates primarily as "coping assistance." Specifically, Thoits hypothesized that the deleterious impact of a stressful situation is modified when other people help someone change the situation itself (e.g., providing child-care assistance to an overworked parent), alter the meaning it has (e.g., helping a friend see a stressful situation from a different, less distressing perspective), and/or change the individual's affective response to the stressor (e.g., providing someone who is anxious and cannot sleep with sleeping pills). Others have proposed that by enhancing self-esteem and a sense of control over the environment, social support helps to engender positive emotional experiences, thereby reducing the negative effects of stress (Pearlin, Lieberman, Menaghan, & Mullan, 1981). Again, as in the direct effect versus buffering issue, the proposals are not

mutually exclusive. Instrumental, concrete aid provided by others and less concrete emotional support and self-esteem enhancement may both be important aspects of social support functioning.

The third issue, the focus of social support, was addressed in some detail by Cohen and Syme (1985), who examined the impact of social support on disease etiology and on recovery from illness. Social support is conceptualized by these authors as a positive factor that aids in the maintenance of health as well as in disease recovery. There have been several proposals regarding the mechanism of social support's positive effects on health (the final issue just mentioned). By enhancing self-esteem and positive feelings, social support may indirectly strengthen the immune system, thereby speeding recovery from illness and reducing susceptibility to disease (Cohen & Syme, 1985; Jemmott & Locke, 1984). Supportive relationships with others may also aid in health maintenance and recovery by helping to promote healthy behaviors (e.g., compliance with prescribed health care, smoking cessation, etc; Brownell & Shumaker, 1984).

A number of scales designed to measure social support have been described in the literature (for reviews of these measures, see Bruhn & Philips, 1984; House & Kahn, 1985; and Tardy, 1985). Both quantitative measures of support (e.g., the number of friends one can turn to in a crisis) and qualitative measures (e.g., perceptions of social support adequacy) have been investigated. Some researchers have reported a significant inverse relationship between quantitative measures of social support and psychological states such as depression and anxiety (Andrews et al., 1978; Brandt & Weinert, 1981; Sarason et al., 1983; Sarason et al., 1985; Schaefer et al., 1981; Wilcox, 1981). However, most authors have found perceived social support to be a better predictor of psychological status than objectively measured social support (Barrera, 1981; Brandt & Weinert, 1981; Sarason et al., 1985; Schaefer et al., 1981; Wilcox, 1981). As Sarason et al. (1983) suggested, it may be that the size of a social support system and the satisfaction with the support received from that system are two different dimensions of social support, each of which is independently important in terms of coping with stress.

The purpose of this article is to describe the development of the Multidimensional Scale of Perceived Social Support (MSPSS), a new instrument that has a number of qualities which make it a useful addition to the social support scales already in existence. First of all, the MSPSS specifically addresses the subjective assessment of social support adequacy. Gore (1978), Lin et al. (1979), and Norbeck, Lindsey, and Carrieri (1981) failed to analyze separately the quantitative and qualitative aspects of social support. Other scales focus exclusively on the objective or quantitative measurement of social support (Andrews et al., 1978; Donald & Ware, 1984).

Secondly, the MSPSS was designed to assess perceptions of social support adequacy from three specific sources: family, friends, and significant other. Although some other scales contained items addressing these sources of support,

most did not consider them as potentially separate, distinct subgroupings. Procidano and Heller (1983) looked at friends and family separately, but did not include significant others as a category. Holahan and Moos (1983) considered family and work relationships as potentially distinct sources of support, but obtaining measures of these two areas required the administration of two rather lengthy questionnaires, the Family Environment Scale (Moos & Moos, 1981) and the Work Environment Scale (Moos, 1981).

Thirdly, in our study, the MSPSS is shown to be psychometrically sound, with good reliability, factorial validity, and adequate construct validity. Reliability was not determined adequately for several scales developed previously (Andrews et al., 1978; Gore, 1978; Monroe et al., 1983). Brandt and Weinert (1981), Schaefer et al. (1981), and Wilcox (1981) failed to establish the factorial validity of the subscales they identified.

Finally, the MSPSS is self-explanatory, simple to use, and time conserving—features that make it an ideal research instrument for use when subject time is limited and/or a number of measures are being administered at the same time. A number of the other scales that have been developed are more time consuming to complete and/or difficult to administer (Barrera, 1981; Brandt & Weinert, 1981; Holahan & Moos, 1983; McFarlane, Neale, Norman, Roy, & Streiner, 1981; Norbeck et al., 1981; Sarason et al., 1983; Schaefer et al., 1981).

In our study, both the internal reliability (Cronbach's coefficient alpha) and test-retest reliability of the MSPSS are established. Factor analysis is used to determine the validity of considering different sources of support as distinct from one another. The construct validity of the scale is addressed by investigating the relationship between perceived social support and the presence of the symptoms of depression and anxiety. It is hypothesized that high levels of perceived social support will be associated with low levels of depression and anxiety symptomatology.

METHOD

Subjects

The Multidimensional Scale of Perceived Social Support (MSPSS) and the Hopkins Symptom Checklist (HSCL; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) were administered to 275 Duke University undergraduates enrolled in an introductory psychology course (136 women, 139 men). The subjects ranged from 17 to 22 years of age ($M = 18.6$, $SD = .88$). The sample included 185 freshmen, 67 sophomores, 20 juniors, and 3 seniors. Of the 275 total subjects, 69 were retested as a reliability measure (39 women, 30 men). This group ranged from 17 to 21 years of age ($M = 18.5$, $SD = .90$) and consisted of 45 freshmen, 20 sophomores, 20 juniors, and 3 seniors.

Instruments and Administration

The HSCL and the MSPSS were administered to the subjects as part of a group testing format in which the students were required to complete a number of paper-and-pencil inventories as a course requirement.

The HSCL is a 58 item, self-report inventory designed to assess the degree to which symptoms associated with various problem areas are present. The five problem dimensions include: somatization, obsessive-compulsive behavior, interpersonal sensitivity, anxiety, and depression. In view of the consistent finding by many investigators of the strong inverse relationship of social support with depression and anxiety, only these two problem dimensions were investigated in this study. The reliability and validity of the HSCL has been demonstrated and reported by Derogatis et al. (1974).

The MSPSS, the subject of this article, was designed to be a quick and easily administered inventory for the measurement of subjective social support.

Scale Construction and Revision

Initially, the MSPSS was constructed with 24 items addressing relationships with family, friends, and a significant other in the following areas: social popularity (e.g., "I receive invitations to be with others"), respect (e.g., "People look up to me"), and items directly related to perceived social support (e.g., "I get the help and support I need from my friends"). Each item was rated on a 5-point Likert-type scale ranging from *strongly disagree* (1) to *strongly agree* (5). The results of several pilot studies led to the changes described later and to the revised and current version of the MSPSS.

First, repeated factor analyses indicated that the items that did not directly address perceived social support (i.e., those that addressed popularity and respect) did not form consistent, conceptually clear factors. For this reason, these items were excluded. The present MSPSS includes only 12 items. These are listed in Table 1. Second, the items directly addressing social support tended to divide into factor groups relating to the source of the support (i.e., Family, Friends, or Significant Other). Each of these groups consisted of four items. Finally, in an attempt to increase response variability and minimize a ceiling effect, a 7-point rating scale ranging from *very strongly disagree* (1) to *very strongly agree* (7) was implemented.

RESULTS

Confirmatory Factor Analysis

The Kaiser normalization test, (Statistical Package for the Social Sciences, Inc., 1983) which uses criteria based on several values (e.g., eigenvalue size and

TABLE 1
Multidimensional Scale of Perceived Social Support Item and Subscale Means and Standard Deviations

<i>MSPSS Items</i>	<i>M</i>	<i>SD</i>
1. There is a special person who is around when I am in need.	5.55	1.37
2. There is a special person with whom I can share my joys and sorrows.	5.83	1.43
3. My family really tries to help me.	6.22	1.07
4. I get the emotional help and support I need from my family.	5.62	1.49
5. I have a special person who is a real source of comfort to me.	5.70	1.51
6. My friends really try to help me.	5.78	1.02
7. I can count on my friends when things go wrong.	5.77	1.22
8. I can talk about my problems with my family.	5.38	1.59
9. I have friends with whom I can share my joys and sorrows.	6.01	1.01
10. There is a special person in my life who cares about my feelings.	5.90	1.34
11. My family is willing to help me make decisions.	5.98	1.20
12. I can talk about my problems with my friends.	5.85	1.17
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<i>MSPSS Subscales</i>	<i>M</i>	<i>SD</i>
Significant Other	5.74	1.25
Family	5.80	1.12
Friends	5.85	.94
Total	5.80	.86

number of iterations required), extracted three factors for the principal components factor analysis. The pattern matrix from the oblique rotation, which allows for correlations between the factors, is presented in Table 2. As can be seen, items had high loading on factors for which they were intended with minimal cross-loadings. These results confirmed the subscale groupings the experimenters had expected: perceived support from family, from friends, and from a significant other.

Descriptive Statistics

The means and standard deviations of the three MSPSS subscales and total scale are presented in Table 1. As regards the intercorrelations among subscales, the Significant Other and Friends factors were found to be moderately correlated ($r = .63$). The Family subscale, however, was more independent from the other

TABLE 2
Factor Analysis Pattern Matrix for MSPSS

MSPSS Item	Factors		
	Significant Other	Family	Friends
1	.74	-.10	-.16
2	.91	.08	.04
5	.91	.03	.00
10	.92	.00	.01
3	.03	.83	.00
4	.07	.84	.00
8	.04	.84	.03
11	-.12	.81	-.07
6	.06	.03	-.82
7	.06	.00	-.79
9	.09	-.02	-.86
12	-.10	.03	-.86

two, with correlations of .24 and .34 with Significant Other and Friends, respectively. These findings are not surprising for a group of students attending a private university and living away from their families. It is important to note, however, that although there is some overlap between the subscales, the factor analysis clearly demonstrates that the subscales also tap three separate dimensions.

Reliability

Cronbach's coefficient alpha, a measure of internal reliability, was obtained for the scale as a whole as well as for each subscale. For the Significant Other, Family, and Friends subscales, the values were .91, .87, and .85, respectively. The reliability of the total scale was .88. These values indicate good internal consistency for the scale as a whole and for the three subscales.

Sixty-nine of the 275 subjects were retested 2 to 3 months after initially completing the questionnaire. The test-retest reliability for the Significant Other, Family, and Friends subscales were .72, .85, and .75, respectively. For the whole scale, the value obtained was .85. In effect, the MSPSS demonstrated good internal reliability and adequate stability over the time period indicated.

Construct Validity

One of the hypotheses underlying the development of this instrument was that perceived social support would be negatively related to reported anxiety and

depression symptoms. Support for this prediction was demonstrated by correlations between the MSPSS subscales and the Depression and Anxiety subscales of the HSCL. Perceived support from Family was significantly inversely related to both depression, $r = -.24$, $p < .01$, and anxiety, $r = -.18$, $p < .01$. Perceived support from Friends was related to depression symptoms, $r = -.24$, $p < .01$, but not to anxiety. The Significant Other subscale was minimally but significantly negatively related to depression, $r = -.13$, $p < .05$, as was the scale as a whole, $r = -.25$, $p < .01$.

Analyses of Gender Differences

In looking at the MSPSS and HSCL correlations by sex of subjects, an interesting finding emerged. In this sample, the correlation between perceived support from friends and depression symptoms was $-.43$ for men and only $-.21$ for women. Although each was significant at or above the $.01$ level, the shared variance for men was 16.8% in contrast to 4.4% for women. This difference was not statistically significant, and cannot be generalized to other groups of subjects, but it does bear further investigation.

Using one-way analyses of variance (ANOVA), men's scores on the MSPSS and on the two HSCL subscales were compared with women's scores. The *M*, *SD*, and *F* values are presented in Table 3. Women reported receiving significantly greater support than men from a significant other, from friends, and overall: $F(1, 273) = 20.28$, $p < .001$; $F(1, 273) = 32.73$, $p < .001$; and $F(1, 273) = 24.38$, $p < .001$, respectively. However, there was no significant gender effect with respect to reported support from the family. In terms of the HSCL, men reported significantly fewer symptoms of both depression and anxiety than women: $F(1, 273) = 6.55$, $p < .05$, and $F(1, 273) = 7.94$, $p < .01$, respectively.

TABLE 3
MSPSS and HSCL Means and Standard Deviation by Gender

Scale	Men		Women		F
	M	SD	M	SD	
MSPSS					
Significant Other	5.42	1.30	6.08	1.11	20.28***
Friends	5.55	.93	6.16	.84	32.73***
Family	5.70	1.04	5.90	1.20	2.34
Total	5.55	.84	6.05	.81	24.38***
HSCL					
Depression	1.50	.36	1.63	.44	6.55*
Anxiety	1.31	.33	1.44	.42	7.94**

* $p < .05$. ** $p < .01$. *** $p < .001$.

DISCUSSION

The results of this study indicate that the MSPSS is a psychometrically sound instrument. Adequate internal and test-retest reliability have been demonstrated as well as strong factorial validity and moderate construct validity. Additionally, as a self-explanatory 12-item inventory, it is brief and simple to use, making it particularly valuable for research when time limitations are present.

The factor analysis demonstrates that the subjects clearly differentiated between the three sources of perceived social support (i.e., family, friends, and a significant other). This finding confirms and extends Procidano and Heller's (1983) demonstration of friends and family as independent and internally consistent sources of social support. In addition, it suggests that studies which fail to consider the source of support may lose important information. In this sample of college students, for example, perceived support from family was more strongly inversely related to depression than was perceived support from a significant other. With other subject groups (e.g., older individuals and psychiatric patients), one of the other sources of support may prove to be a better predictor of physical or psychological health. Further explorations into this issue are called for.

In terms of gender effects, women reported both greater social support from friends and a significant other, and more symptoms related to anxiety and depression than men. This finding replicates a body of research which has demonstrated that women report more depression than men (Radloff & Rae, 1979; Weissman & Klerman, 1977). These results may arise because women are more willing than men to report symptoms of anxiety and depression. Alternatively, despite greater perceived social support, college women may experience more symptoms of stress than college men.

It is also interesting to note that the relationship of perceived support from friends to depression was stronger for men than for women in this sample. Even though men reported less support and fewer symptoms overall than women, depression symptoms and perceived support from friends were more highly correlated for men than for women. It is important to note, however, that Sarason et al. (1983) found the opposite pattern in a similar sample of college students (i.e., social support and depression were more highly related for women than for men). Also, the difference in correlation between men and women was not statistically significant. Therefore, this gender difference needs to be substantiated by future research.

Although evidence indicates that the MSPSS is a sound research instrument, there are several issues remaining to be addressed. First, as stated earlier, the MSPSS has been tested with a relatively homogeneous, normative sample of college students. It would be important, therefore, to investigate the psycho-

metric properties and factor structure of the MSPSS with subjects drawn from other populations. Also, it is probable that the meaning of family as a source of support changes across the life cycle. For the college students in this study, family was most likely taken to mean family of origin, whereas older individuals with families of their own would be liable to see their current families as the point of reference.

Second, the item means of the MSPSS all fell well above the midpoint of 3.5, suggesting infrequent endorsement of lower levels of social support. One possible explanation for this finding is that the college students in our study perceived themselves to be highly supported by their social environment. Another possibility that needs to be explored further, is the tendency of this instrument to pull for responses in the socially desired direction of reporting higher levels of perceived social support.

Third, Cohen and McKay (1984), Gore (1981), and House (1981) argued that social support acts more strongly as a moderator between stressful life events and physical or psychological symptoms (buffering hypothesis). For people under stress, social support is believed to be strongly negatively correlated with symptomatology. For those not under stress, the relationship between support and symptomatology is believed to be minimal. Therefore, although moderate evidence for construct validity in our study was provided by the significant but low level of MSPSS/HSCL correlations, further research that takes into account the relative quantity of life stress may yield a higher level of construct validity for the MSPSS. In fact, a group of researchers using an early version of the MSPSS addressed the buffering hypothesis by looking at the relationships of a personality variable (Type A vs. Type B personality) and social support to coronary artery disease (Blumenthal et al., 1987). They found that social support, as measured by the MSPSS, acted as a buffer. That is, although they reported no main effect for social support across personality type, they found that Type A individuals (i.e., individuals who tend to be very driven and maintain a great deal of stress in their lives) with high levels of perceived social support had less coronary artery disease than their counterparts with low levels of perceived support. This relationship did not hold for Type B individuals (i.e., people who maintain a more relaxed lifestyle).

Fourth, as discussed earlier, there may be additional sources of support for a variety of subject groups that need to be taken into consideration when studying perceived social support with unique populations (e.g., pets, mentors, and psychotherapists). Holahan and Moos (1983), for example, investigated work relationships as sources of social support.

Finally, it is important to note that the causal direction of the social support and symptomatology relationship cannot be defined in our correlational study. The causal nature of this relationship can only be clarified with carefully designed longitudinal research.

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