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The Relationship Between Lifestyle and Hope for Life with Social Support in Young Adults with Physical-Motor Disabilities in Tehran

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ABSTRACT

The present study aimed to examine the relationship between lifestyle and hope for life with social support among young adults with physical-motor disabilities in the city of Tehran. This research was correlational in nature and fundamental in terms of purpose. The statistical population consisted of young individuals aged 20 to 35 years with physical-motor disabilities residing in four care and support centers in Tehran in 2023. From an accessible population of 400 individuals, a sample of 196 participants was selected through simple random sampling using the Morgan table. Data collection instruments included the Lifestyle Questionnaire (LSQ), Phillips Social Support Questionnaire, and Snyder et al.'s Hope Scale (1991). Pearson correlation and multiple regression analyses were conducted using SPSS version 26. The results showed a positive and significant relationship between lifestyle and social support ($r = 0.313$, $p < 0.01$). Additionally, a positive and significant relationship was observed between hope for life and social support ($r = 0.225$, $p < 0.01$). The results of the multiple regression analysis also indicated that lifestyle and hope for life together explained approximately 10% of the variance in social support ($R^2 = 0.101$, $p < 0.01$). These findings suggest that improving lifestyle and enhancing hope for life can lead to increased social support among young adults with physical-motor disabilities. Attention to these components can be effective in the design of support, rehabilitation, and mental health promotion programs for this group.

Keywords: lifestyle, hope for life, social support, youth, physical-motor disability

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Introduction

In today's world, where social, cultural, and technological changes occur at an accelerated pace, the quality of life of various social groups—particularly special populations such as individuals with disabilities—has increasingly attracted the attention of researchers in the fields of psychology, sociology, and health sciences

(1-5). In this regard, social support is a concept referring to an individual's perception of acceptance, care, interest, and support from others such as family, friends, and society. Empirical evidence has shown that social support can play a buffering and protective role in stressful situations and positively influence individuals' psychological adjustment (6). Accordingly, social support has been identified as a key construct in the quality of life of patients, the elderly, and individuals with physical-motor disabilities (7, 8). Specifically, individuals with disabilities, due to physical limitations and restricted social interactions, have a greater need for receiving social support than others (9). Several studies have confirmed a positive relationship between social support and hope for life (10, 11).

Hope for life, as one of the fundamental constructs of positive psychology, plays a critical role in explaining resilience, motivation, and mental health. Snyder and colleagues developed the theory of hope based on two components: agency thinking (goal-directed energy) and pathway thinking (planning to achieve goals). Both components are enhanced through interaction with environmental resources and social support (12). Research has shown that perceived social support is one of the strongest predictors of hope for life and can mitigate the negative effects of illness, loneliness, and social deprivation (6, 13). Moreover, among adolescents and young adults, hope for life is not only a cognitive construct but also a key element in identity formation, making sense of experiences, and coping with the social stigma associated with disability (14).

Another essential component in the quality of life of individuals with disabilities is a healthy lifestyle. Lifestyle refers to a set of behaviors, habits, and attitudes associated with one's physical, mental, and social well-being. In recent years, a healthy lifestyle has been defined by indicators such as proper nutrition, physical activity, mental well-being, spirituality, healthy social relationships, and the avoidance of risky behaviors (15, 16). Studies show that a healthy lifestyle in individuals with disabilities can play a protective role against psychological disorders and increase self-efficacy, social competence, and hope (17, 18). Furthermore, in research focusing on health-promoting lifestyles, it has been demonstrated that social support and mental health are two essential prerequisites for adopting healthy behaviors (19, 20).

The interrelation of these three variables—lifestyle, hope for life, and social support—has also been examined through structural models. For instance, a study on patients with multiple sclerosis found that lifestyle could affect quality of life through the mediating role of psychological capital (21). Additionally, results from structural equation modeling research have shown that social support directly and indirectly—via hope for life and psychological adjustment—affects individuals' well-being (11, 13). Other findings also suggest that meaning and purpose in life training can improve resilience, perceived social support, and negative affect among students (22).

In Iran, despite efforts in education, rehabilitation, and welfare services, numerous challenges remain in improving the quality of life of individuals with physical-motor disabilities. Many young people with motor disabilities, when faced with environmental barriers, negative social attitudes, and limited educational and employment opportunities, experience a decline in hope and reduced social participation (23). In some regions, moreover, a culture of dependency and a patronizing attitude can hinder the development of psychological independence and social responsibility in individuals with disabilities (24). However, promoting a healthy lifestyle and creating opportunities for effective social support can play a foundational role in enhancing hope and quality of life among these groups.

Globally, various studies have also focused on the role of gender, cultural differences, and social inequalities in the reception of social support and the formation of lifestyle patterns. For example, research among African American citizens in the United States has shown that gender differences in disease management styles and perceived social support affect their quality of life (25). Similarly, among cancer patients, spiritual caregiving needs and perceived social support have been reported as significant predictors of hope for life (8).

Given the above, investigating the relationship between lifestyle, hope for life, and social support in young adults with physical-motor disabilities holds significant theoretical and practical importance. On one hand, this study can fill the gaps in the scientific literature regarding the interaction of these variables in the Iranian context; on the other hand, its findings can be utilized in the development of intervention programs grounded in positive psychology, social policymaking, and the planning of supportive services in welfare and rehabilitation centers. The present study aims, through an empirical approach, to provide a clear picture of these relationships and outline practical pathways to enhance the psychological and social well-being of young people with disabilities.

Methods and Materials

Study Design and Participants

This study employed a correlational research design and, in terms of purpose, is classified as basic research. The statistical population consisted of all young adults with physical-motor disabilities aged 20 to 35 years in four specialized centers for individuals with disabilities in Tehran during the year 2023. The estimated population was approximately 1,000 individuals, from which 400 participants were selected using convenience sampling. The inclusion criteria included having only a physical-motor disability and being in the age range of 20 to 35 years. Of the 400 individuals, 250 were male and the rest were female. Subsequently, based on the Morgan table and using simple random sampling, 196 young adults (both male and female) were selected and participated in the research process.

A fieldwork approach was employed for data collection. In the first step, the researcher obtained the necessary research permits from the university. Then, by visiting the Welfare Organization of Tehran and presenting an official letter of introduction, permission was obtained to access the four centers for individuals with physical-motor disabilities. The researcher collected the data simultaneously across the four centers using a combination of convenience and random sampling. In this phase, the Phillips Social Support Questionnaire was first distributed to the participants. After 20 minutes, the Lifestyle Questionnaire (LSQ) was administered, and finally, with a similar time interval, the Snyder et al. Hope Scale (1991) was distributed among the participants. Ethical research principles such as informed consent and confidentiality of participants' information were observed throughout all stages.

Data Collection

To measure the variable of social support, the Phillips Social Support Questionnaire was used. This instrument contains 23 items on a five-point Likert scale and is completed as a self-report paper-and-pencil format. It was developed in 1986 by Wax, Phillips, and colleagues based on Cobb's definition of social support and assesses three main components: family support, friend support, and support from others. In Iran,

Ebrahimi Ghavam (1992) adapted the tool by modifying the scoring method and evaluated its validity and reliability. Research conducted in Iran (e.g., Shahbakhsh, 2010, and Khabaz et al., 2012) has shown that the questionnaire possesses good reliability, with Cronbach's alpha coefficients for the entire scale reported between 0.74 and 0.91 in various studies.

To assess lifestyle, the Lifestyle Questionnaire (LSQ) was used. This instrument includes 70 four-choice questions based on a Likert scale and is also completed as a self-report paper-and-pencil tool. The dimensions assessed by this questionnaire include physical health, exercise and fitness, weight control and nutrition, disease prevention, psychological health, spiritual health, social health, drug avoidance, accident prevention, and environmental health. Responses are scored from 0 to 3 (ranging from "never" to "always"). The total score ranges from 0 to 210, with lifestyle classified into three levels: poor (0–70), moderate (70–105), and strong (above 105). In the study by Lali et al. (2012), construct validity was confirmed through factor analysis, and Cronbach's alpha for the entire questionnaire was reported at 0.87, with subscale alphas ranging from 0.76 to 0.89, indicating strong reliability and validity for lifestyle assessment.

To evaluate hope for life, the Adult Hope Scale by Snyder et al. (1991) was employed. This tool contains 12 items scored on an eight-point Likert scale (ranging from "completely false" to "completely true"). It consists of two subscales: agency thinking (items 2, 9, 10, and 12) and pathway thinking (items 1, 4, 6, and 8). Four items (3, 5, 7, and 11) are considered distractors and are not included in scoring. The total score range of the instrument is from 8 to 64, with higher scores indicating a higher level of hope. According to studies by Snyder et al. (1991) and domestic researchers such as Ghabari Bonab et al. (2007) and Kermani et al. (2011), the scale has demonstrated acceptable reliability. Cronbach's alpha coefficients have been reported between 0.82 and 0.86 for the total scale and between 0.77 and 0.88 for the subscales in Iranian studies. Multiple sources have also supported its construct, concurrent, and content validity both internationally and domestically.

Data analysis

Descriptive and inferential statistical methods were used for data analysis. In the descriptive section, indicators such as mean, median, mode, standard deviation, and variance were used to describe the characteristics of the statistical sample. In the inferential section, Pearson correlation and multivariate regression tests were used to examine the research hypotheses. Data analysis was conducted using SPSS software version 26, and the significance level for hypothesis testing was set at $p < 0.01$. All analyses were carried out to address the main objectives of the study and explore the relationships between lifestyle, hope for life, and social support in young adults with physical-motor disabilities.

Findings and Results

In this study, a total of 196 young adults with physical-motor disabilities from Tehran participated. In terms of age distribution, 37 participants (18.9%) were in the age range of 18 to 25 years, 140 participants (71.4%) were between 26 and 35 years, 17 participants (8.7%) were between 36 and 45 years, and 2 participants (1.0%) were in the 46 to 56-year range. Additionally, gender distribution was equal, with 98 participants (50%) being female and 98 (50%) male. This relatively balanced gender distribution also allows for analysis and comparison from a gender-based perspective.

Table 1. Descriptive Statistics for the Variables of Lifestyle, Social Support, and Hope for Life

Variables	N	Minimum	Maximum	Mean	Standard Deviation
Physical Health	196	12	24	17.61	2.934
Exercise & Fitness	196	7	26	14.32	4.592
Weight Control & Nutrition	196	7	27	16.62	3.847
Disease Prevention	196	7	28	20.12	3.420
Psychological Health	196	7	28	18.21	5.274
Spiritual Health	196	8	28	19.88	5.101
Social Health	196	9	28	20.39	4.554
Drug Avoidance	196	8	28	21.76	5.418
Accident Prevention	196	7	28	21.38	4.723
Environmental Health	196	7	28	20.90	4.091
Total Lifestyle Score	196	84	259	191.19	29.572
Family Support	196	11	35	24.40	4.525
Friend Support	196	8	40	26.11	5.133
Others' Support	196	15	42	27.67	5.328
Total Social Support	196	36	113	78.18	12.916
Agency Thinking	196	10	42	27.18	6.292
Pathways	196	10	35	23.14	6.142
Total Hope for Life	196	25	76	50.42	11.024

The table above presents descriptive indicators including minimum and maximum scores, means, and standard deviations for the variables of lifestyle, social support, and hope for life. The results show that the mean lifestyle score among participants was 191.19 with a standard deviation of 29.572, indicating a relatively favorable level of lifestyle in this group. Among the subscales of lifestyle, the highest mean was related to the drug avoidance component (21.76), and the lowest was related to exercise and fitness (14.32). Moreover, the total mean score of social support was reported to be 78.18 with a standard deviation of 12.916, reflecting a moderate to high level of social support in this population. Finally, the mean score for hope for life was 50.42 with a standard deviation of 11.024, indicating a relatively good level of hope for the future among participants. These indicators provide the foundation for subsequent inferential statistical analyses.

Prior to conducting inferential statistical analyses, the key assumptions of correlation and regression tests were examined. First, the normality of the distribution of variables was assessed using the Kolmogorov-Smirnov test, and the results indicated that all the main research variables followed a normal distribution ($p > 0.05$). Additionally, scatterplots and correlation coefficients between variables confirmed the presence of linear relationships, thus satisfying the assumption of linearity. Multicollinearity was assessed through intercorrelations among the independent variables, and none of the correlation coefficients exceeded the critical threshold of 0.90, indicating no multicollinearity problem. The Durbin-Watson statistic was calculated at 1.98, which falls within the acceptable range of 1.5 to 2.5, confirming the independence of errors. Furthermore, the residual plots demonstrated random dispersion and normality of errors. Based on these results, all essential assumptions for performing regression and correlation analysis were confirmed, and the necessary conditions for inferential analysis were met.

Table 2. Correlation Matrix Between Lifestyle and Hope for Life with Social Support

Variables	Hope for Life	Lifestyle
Social Support	0.225**	0.313**
Significance Level	0.002	0.000
N	196	196

The findings in Table 2 show that there is a positive and significant correlation between social support and lifestyle ($r = 0.313$, $p < 0.01$). Additionally, a positive and significant correlation was observed between social support and hope for life ($r = 0.225$, $p < 0.01$). These results indicate that higher levels of healthy lifestyle and hope for life are associated with increased levels of perceived social support. Overall, the findings from this table confirm the main hypothesis of the study, which posits a significant relationship between lifestyle and hope for life with social support.

Table 3. Regression Model of Lifestyle and Hope for Life in Predicting Social Support

Multiple Correlation Coefficient (R)	Coefficient of Determination (R^2)	Adjusted R^2	Standard Error of the Estimate
0.317	0.101	0.091	12.313

The results in Table 3 show that the multiple correlation coefficient between lifestyle and hope for life with social support is 0.317, indicating a moderate and positive relationship between the predictor variables and the criterion variable. The coefficient of determination (R^2) is reported as 0.101, suggesting that approximately 10% of the variance in social support is explained by the two variables of lifestyle and hope for life. The adjusted R^2 is 0.091, which represents the proportion of variance explained after adjusting for potential errors. The standard error of the estimate is reported as 12.313, serving as a measure of the model's prediction accuracy.

Table 4. Analysis of Variance (ANOVA) for the Regression Model of Lifestyle and Hope for Life in Predicting Social Support

Source	Sum of Squares	df	Mean Square	F	Significance Level
Regression	3270.944	2	1635.472	10.787	0.001
Residual	29260.443	193	151.609		
Total	32531.388	195			

Table 4 presents the results of the analysis of variance (ANOVA) for the regression model. According to the results, the F-statistic is 10.787, with a significance level of less than 0.001 ($p < 0.01$), indicating that the regression model is statistically significant. This means that the combination of the predictor variables—lifestyle and hope for life—plays a significant role in predicting social support. In other words, we can state with 99% confidence that the proposed model in this study is statistically meaningful, and the independent variables are capable of explaining the criterion variable.

Discussion and Conclusion

The findings of the present study revealed a significant positive relationship between lifestyle and social support among young adults with physical-motor disabilities. The correlation coefficient between these two variables was 0.313, with a significance level of less than 0.01. This indicates that the healthier the lifestyle observed in these individuals, the higher their perceived level of social support. Additionally, a significant positive relationship was also reported between hope for life and social support ($r = 0.225$, $p < 0.01$). The results of the multiple regression analysis showed that the variables of lifestyle and hope for life together explained approximately 10% of the variance in social support. These findings suggest that improving lifestyle and increasing hope for life can facilitate greater social support for this specific segment of society.

The above results can be interpreted through the lens of social and positive psychology theories. According to Snyder's theory, hope for life is a cognitive construct consisting of agency thinking (goal-directed

motivation) and pathways thinking (planning routes to goals). These two components are reinforced by social support and, in turn, also influence perceived support (6, 12). This finding aligns with numerous international studies. For example, the study by Hsu et al. demonstrated that among cancer patients, hope for life mediates the relationship between body image and resilience, and that social support strengthens this relationship (11). Likewise, in the research by Xiang et al., a longitudinal causal relationship between social support and hope was confirmed in adolescents, with social support considered a powerful source for the formation and sustainability of hope against despair and social pressure (10).

The present study's findings are also consistent with research by Mana et al., which showed that social support influences academic self-efficacy through the mediating role of hope (13). These findings emphasize the fundamental role of social and interpersonal resources in enhancing cognitive-emotional constructs such as hope. At the national level, the findings align with research by Abedi et al., who reported that training based on Choice Theory effectively increased hope for life among married women (17). Similarly, the study by Budak and Kaatsız confirms that in oncology patients, social support is a predictor of hope, and higher levels of received support are associated with greater hope for the future (8).

Regarding the relationship between lifestyle and social support, the findings of this study are comparable to several others. In the study by Beyk et al., spiritual lifestyle was related to adolescent happiness through psychological well-being (15). Likewise, Rostamnezhad et al. demonstrated in a structural model that lifestyle can predict quality of life in patients with multiple sclerosis through the mediating role of psychological capital (21). Their study also showed that a healthy lifestyle affects not only physical health but also social relationships and supportive resources. The present study's findings indicate that individuals with healthier lifestyles, through prosocial behavior, effective human interaction, and spirituality, are better equipped to receive social support.

Numerous studies have confirmed that a healthy lifestyle among individuals with chronic illnesses and physical disabilities may be associated with social support. Alizadeh et al. found a significant positive correlation between lifestyle and social support in women with multiple sclerosis, and that received social support predicted lifestyle outcomes (9). Additionally, Hajimiri et al. emphasized that general health and social support play a major role in shaping health-promoting lifestyles among postpartum mothers (19). The current study’s results are consistent with these findings, showing that even in the context of physical disability, lifestyle is improvable and becomes more stable with the help of social support.

From a theoretical perspective, these relationships can be analyzed using interactionist frameworks grounded in social psychology. A healthy lifestyle—especially in psychological, spiritual, social, and risk-avoidance dimensions—naturally facilitates more positive interpersonal interactions and increases social capital. This process leads to the expansion of actual and perceived support networks. Simultaneously, the existence of social support networks can provide the motivation, psychological energy, and resources necessary to adopt and maintain a healthy lifestyle. Therefore, the relationship between these variables is reciprocal and reinforcing, and the present research takes a significant step toward analyzing this mutual cycle among the vulnerable population of young adults with physical-motor disabilities.

Moreover, the results align with studies emphasizing the role of educational programs focused on meaning, purpose, and social support in promoting mental health. For instance, the study by Karimi Dastaki and Mahmudi showed that meaning-centered therapy workshops improved resilience and social support

among students (22). The study by Pione et al. also highlights the importance of measuring and enhancing hope and resilience in caregivers of dementia patients, noting their effect on quality of life and reduction of psychological burnout (14).

At the same time, the findings are consistent with research such as that of Hanachi et al., who emphasize that socio-cultural differences and ethnic backgrounds can influence the receipt of social support and styles of social interaction—a factor particularly relevant for the population under study (young people with mobility limitations) (23). Furthermore, the study by Fahim et al. on lifestyle during the COVID-19 pandemic in Bangladesh showed that environmental and psychological stress can disrupt lifestyle and reduce social support (18).

Therefore, the findings of this study not only align with existing literature but also underscore the importance of simultaneously examining these three components—lifestyle, hope for life, and social support—within a specific community (young adults with physical-motor disabilities in Iran). This group, due to confronting physical barriers, negative societal attitudes, and structural challenges, requires more than others interventions based on positive psychology, healthy lifestyle education, and the strengthening of social support resources.

Among the limitations of this research is the use of convenience sampling and the focus on specific centers in Tehran, which may restrict the generalizability of the findings to the broader national context. Furthermore, the use of self-report tools increases the risk of response bias. Contextual variables such as the severity of disability, level of education, or economic status were not controlled in the analyses, which could influence the results.

Future research can explore causal relationships among the variables using longitudinal designs and examine mediating or moderating roles of constructs such as psychological capital, resilience, and spiritual support. It is also recommended that similar studies be conducted in other cities with greater cultural diversity. Employing qualitative methods to explore the lived experiences of individuals regarding lifestyle, hope, and social support can further enrich both theoretical and applied literature.

Based on the findings, it is recommended to design and implement empowerment and educational programs focused on healthy lifestyle promotion in rehabilitation centers, welfare organizations, and universities for young people with disabilities. Furthermore, expanding social support networks through civil institutions, families, and peers could significantly contribute to enhancing hope for the future among these individuals. Educating families and caregivers on the importance of emotional, social, and psychological support can also serve as a foundation for improving the mental health and quality of life of this specific population.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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