

The Effect of Perceived Social Support on Health Behavior among Patients with Chronic Illnesses

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Abstract: This study explored how perceived social support shapes health behaviors among individuals living with chronic illnesses. Although social support is often regarded as a crucial resource, we hypothesized that generalized forms of support may not always lead to meaningful health behavior change, especially when not tailored to the specific demands of managing a chronic condition.

the study included 112 participants diagnosed with a range of chronic illnesses. Data were gathered through two validated instruments: the Perceived Social Support Scale and the Health Behavior Scale.

Overall, participants reported feeling moderately to highly supported, and their engagement in health-related behaviors was similarly above average. regression analysis indicated that social support explained only 14% of the variance in health behaviors, suggesting its limited role as a standalone predictor. when examining the different sources of support, only support from family members showed a significant predictive relationship with health behaviors.. in conclusion, The quality, focus, and relevance of support—particularly when it resonates with the unique challenges faced by those with chronic illnesses—matter more than its mere presence. Empowering family members and close contacts with a clearer understanding of the patient's condition may be key to offering support that genuinely helps foster healthier choices.

Keywords: Perceived social support; Health behavior; Chronic illness, Effect.

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1- Introduction

Chronic diseases are one of the most serious issues confronting modern health systems, especially in light of the continuous increasing in their incidence and the serious implications they have for people and society. These chronic diseases are webbed with health behaviors and therapeutic management including both lifestyle and some liberating medical treatments, much of this becoming a very familiar element of the hospital or day to day activities for the patient. Since those living with chronic diseases must follow a precise health regime, which includes a healthy lifestyle, medication, physical activity, and continuous health monitoring, all crucial for controlling the disease and reducing risk and complications (Chunni et al., 2025).

The increasing prevalence of chronic illnesses and the resultant severity of their consequences have drawn more scholarly attention, and researchers have focused more on chronic illnesses to understand the most pressing issues related to their impact (Abdel-Samad, 2020, p. 206). Although endocrine disorders, diabetes, and hypertension represent specific and common conditions, the low consideration to the psychological and social factors affecting patients adaptation, has not yet become the focus of attention (Kim et al., 2023). In this context, the construct of perceived social support is considered one of the main psychosocial variables that can significantly contribute to health behavior promotion among populations affected by chronic diseases [8].

Perceived social support is described as the subjective-level feeling by an individual to have access to a network of social relations providing them with emotional, informational or tangible support (Uchino, 2009).

Others have suggested that perceived social support is not limited to a narrow time frame of interaction, In other words, Instead, it is a more generalized conviction that tuned-in others will be present in times of distress or when we let our guard down. Support nurtures emotional practicality, psychological strength – two vital elements needed to face the realities of life with chronic illness. Research consistently demonstrates that the availability of this type of support (emotional, informational, or instrumental) is essential to reducing anxiety and depression and improving psychosocial and physical quality of life among persons with chronic diseases (Shen et al.

These results highlight the double role of the perceived social support, as a protective buffer against distress, as well as an enhancing mediator of adaptation. The duality of its role makes it an exciting area to explore, specifically in understanding the mechanics and implications of behaviour related to health (Abe, Erin, Colleen, & Stephen, 2020) It can be speculated that this prompts to a question regarding the manner in which behaviours are modified in response to the actions of close others and how that may relate to health outcomes (Abe, Erin, Colleen, & Stephen, 2020).

Background Although the idea of perceived social support has recently been receiving increasing attention in academic research, we suggest that such research is neither thorough enough nor sufficiently context-based as far as health is concerned, specifically with regard to the needs of socially-supported people with chronic illnesses. Most previous studies have investigated social support on a global or one-dimensional basis, demonstrating a conceptual lack of consideration of the possible separate dimensions or components of social support, and insufficient evaluation of whether these components adequately represent the multi-faceted challenges of managing chronic disease. Irrespective of whether viewed as a uni- vs multi-dimensional construct, previous literature often overlooks the complexity of the relationship between perceived support and challenges relevant to specific health behaviours.

Multiple research findings (e.g. Gallant 2003) have proved that the overall effect of social support on health behavior is conditional on several social context and individual characteristics such as type and source of support, as well as the receiver's subjective assessment of its relevance and sufficiency. These results indicate that social support may be

especially useful when first adjusting to chronic illness, as it can motivate people to engage in targeted health behaviors—in particular, taking medication or adhering to a specific diet. But, most of this output is disconnected and rarely delves deeper. They typically rely on non-specialized measurement instruments or statistical methods that do not distinguish among the dimensions of support.

Additionally, studies (e.g., Fisher et al. (2010)—has demonstrated the role of certain patient characteristics—age, level of education, lifestyle, and more generally the type of pathology (cancer, diabetes, tumor, etc.)—as potential confounding factors of the relationship between perceived social support and health behavior. Such variables are interwoven into the complexity of this issue, and need further, analytical exploration. However, few studies have systematically explored this association by analysing perceived social support through its three main dimensions: family, friend and others, assessing how they are intertwined with health behaviours using regression approaches or suitable variance analysis.

Importantly, while interest in perceived social support as a concept is increasing, there remains a gap in the literature regarding the depth and specificity of research in health contexts—especially regarding the supportive nature of social relationships among chronic disease populations. The majority of studies conducted to date have conceptualised social support as a global or unidimensional construct without investigating the specific features of support or testing whether these features resonate with the multidimensional nature of chronic disease management. Regardless of whether the inherent time frame was treated singularly or dimensionally, perceived support did not emerge as nuanced in terms of its relationship to specific health-related issues.

Many studies, in particular the one by Gallant (2003), show that social support only affects health behavior positively depending on the type of support, its source and the individual subjective perception of if the support was appropriate and sufficient. These results indicate social support may be most impactful in early adaptation to chronic illness and may act as an adherence motivator for select health behaviors (e.g. adhering to a medication regimen, following an appropriate diet). Yet, these findings are still often piecemeal and fail to offer insights at the granular level. Many take the common, but problematic, approach of using general measurement tools or statistical methods that do not account for the distinct components of support.

In addition, Fisher et al. However, individual characteristics and the nature of the illness have been suggested to moderate the relationship between perceived social support and health (Berkman, et al. [21]; Gallant et al. [25]—date; Gallant et al. [457]—date). These variables add a level of detail that deserves a more academic, analytical approach. However, few studies have explored this association with systematic methodological approaches operating with the three main dimensions of perceived social support—family, friends or others—and health behaviours using regression models or suitable variance analysis.

Thus, the present study investigates the association between three main components of perceived social support (i.e., social support from family, friends, and significant others) and health behaviors of chronic illness patients. It also seeks to explore whether such support, in its established form, is a useful provider of stimulus for prolonged health adaptation or whether it exerts its influence in a way that is less than beneficial, because it fails to be behaviorally specific to the particular challenges of chronic disease management.

1.1-Research Questions:

- What is the level of perceived social support among individuals with chronic illnesses?
- What is their level of adherence to healthy behavior?
- Is there a statistically significant correlational relationship between perceived social support and healthy behavior?
- To what extent can healthy behavior be predicted through the dimensions of perceived social support (family support, friends' support, support from others)?

2- Method and Tools:

2.1 – Study Approach:

The predictive descriptive method with possibility to predict the outcome of one variable when the outcome of another variable is already known was adopted for this study. (Fraenkel, Wallen, & Hyun, 2023)

2.2 –Participants:

Participants Selection Method:

This study has 112 chronic illness patients recruited through a convenience sampling using an electronic questionnaire that was sent by digital media platforms.

The diversity of the sample with respect to social characteristics allowed a better understanding of the nature of perceived social support and its influence on participants' health behaviours in their daily lives.

Participants Characteristics:

A – By Age:

Table (1): Participant Characteristics by Age Group

Age Group	Number of Participants	Percentage (%)
Under 30 years	23	20.5%
30 to 39 years	30	26.8%
40 to 49 years	31	27.7%
50 years and above	28	25.0%
Total	112	100%

The range of study participants in four major age groups is presented in **Table 1**. N = 112, total number of participants. The results show that in the sample, the age group "40 to 49 years" had the greatest frequency, representing 26.8 % of the sample indicating that this relatively old age category is noticeably had the greatest concentration within this study. The next most common group was "30 to 39 years" at 24.1%, followed by "under 30 years", which also comprised 24.1%, implying relatively mild representation amongst younger individuals. the 50 years and above group was 25.0% suggesting that there were proportions more representative of older adults in the sample.

- By Gender:

Table (2): Characteristics of Participants by Gender

Gender	Frequency	Percentage
Male	31	27.7%
Female	81	72.3%
Total	112	100%

Table 2 indicates that the majority of participants in the study were female, accounting for 72.3% of the total sample, compared to only 27.7% for males.

-By Educational Level:

Table (3): Characteristics of Participants by Educational Level

Educational Level	Frequency	Percentage
Primary	8	7.1%
Middle school	5	4.5%
Secondary	16	14.3%
University	62	55.4%
Postgraduate	21	18.8%
Total	112	100%

Table 3 shows the classification of the participants according to their qualification level, indicating a great diversity of the sample in terms of education level. The highest frequency within sample is the “University” category (55.4%), which shows that there is an important tendency for better academic qualifications to participate in the study. Coming next is “Postgraduate” category at 18.8% — this shows a relative large amount of participants are holding postgrad degrees — the implication being that there is a difference in awareness of the significance of health and perceived social support by this group. On the other hand, the educational low categories having lower representation, namely: Secondary (14.3%), Primary (7.1%), and Intermediate (4.5%).

- By Marital Status:

Table (4): Characteristics of Participants by Marital Status

Marital Status	Frequency	Percentage
Married	66	58.9%
Divorced	10	8.9%
Single	36	32.1%
Total	112	100%

Table 4 presents the distribution of participants according to their marital status. The **married** category is the most represented, accounting for 58.9% of the total sample. This proportion suggests that the majority of participants in the study belong to a socially stable category in terms of marital relationships, which may influence the nature of perceived social support available to them, particularly when such support comes from a spouse.

The **single** category ranks second, representing 32.1% of the participants. This relatively large proportion indicates a notable segment of the sample who have never been married, and whose perceived social support needs may differ from those of married or divorced individuals, both in terms of its source and its potential influence on their health behaviors.

The **divorced** category constitutes 8.9% of the sample, reflecting a smaller yet meaningful group of participants who have experienced marital separation. This experience may shape the type and extent of perceived social support they receive, whether from family or the broader social environment, and could also be linked to certain health behavior patterns.

- By Economic Status:

Table (5): Characteristics of Participants by Economic Status

Economic Status	Frequency	Percentage
Low	7	6.2%
Medium	78	69.6%
Good	27	24.1%
Total	112	100%

Table 5 presents the distribution of participants according to their economic status. The majority of participants in the study assessed their economic situation as “**Medium**”, representing 69.6% of the total sample. This proportion reflects the general economic condition of a broad segment of participants who live at a relatively stable standard of living—neither enjoying significant affluence nor experiencing severe poverty.

The “**Good**” category ranks second, accounting for 24.1% of participants, indicating a moderate portion of the sample with a relatively high economic standing. In contrast, the “**Low**” category was the least represented, at only 6.2%, yet it still points to a small segment living under economically challenging circumstances. Such conditions may directly influence the quality of perceived social support received, as well as the ability to adhere to health-related behaviors—such as attending medical consultations or purchasing medications.

This distribution, in which middle and upper economic levels predominate, partially reflects the socioeconomic profile of the population targeted in the study, particularly if it

includes individuals with chronic illnesses whose financial condition might be influenced by treatment costs or reduced work capacity.

- By Desired Weight:

Table (6): Characteristics of Participants by Desired Weight

Desired Weight	Frequency	Percentage
Below Desired	9	8.0%
At Desired	65	58.0%
Above Desired	38	33.9%
Total	112	100%

It represents the Distribution of participants according to the desired weight. The most common weight category among participants was “At desired weight,” accounting for 58.0% of the sample. This implies that the majority of the participants are at least somewhat normal weight, which could lead to a greater chance of them adopting and continuing to participate in healthful behaviors.

On the other hand, 33.9% of participants came under “Above desired weight”—an alarming number of participants suggesting potential overweight or obesity in about a third of the sample. The third category, Above desired weight, was the least represented, making up only 8.0% of the sample.

By Regularity of Visiting a Specialist Physician for the Chronic Illness Suffered From:

Table (7): Characteristics of Participants by Regularity of Specialist Visits

Frequency of Visits	Frequency	Percentage
Visit regularly	45	40.2%
Visit rarely	46	41.1%
Do not visit at all	21	18.8%
Total	112	100%

Table 7 presents the distribution of participants according to the frequency of their visits to a specialist physician for the chronic illness they suffer from. The results indicate that the distribution is relatively balanced between the “**Visit rarely**” category (41.1%) and the “**Visit regularly**” category (40.2%). This balance reflects variability in participants’ behaviors toward medical follow-up—while some adhere to regular visits, others limit their consultations to more infrequent intervals.

On the other hand, the “**Do not visit at all**” category accounts for 18.8% of the sample, representing a notable proportion of participants who never consult a physician despite having a chronic illness.

2.3- Study Instruments:

Two instruments were used in the study: **the Perceived Social Support Scale** and **the Health Behavior Scale**.

- Perceived Social Support Scale

In an earlier study, Sahab Al-Rashidi (2018) translated the Multidimensional Scale of Perceived Social Support — SMF (Zimet, Dahlem, Zimet, & Farley, 1988) into Arabic. A final version, translated to Vietnamese, was reviewed by bilingual English exterior language specialists by back-translation to English. The scale has 12 items in three domains — family, friends, and significant others.

Face Validity

The scale was reviewed by a panel of experts from Saudi universities, to assess its validity in measuring perceived social support and its suitability for the Saudi context. Feedback indicated that the instrument possesses face validity. An agreement rate of 90% or higher among the judges was adopted as the criterion for approving each item, which is considered an acceptable standard. Some items were reworded, but no items were removed.

Reliability

To verify the reliability of the study instrument, the test–retest method was employed. The scale was administered and then re-administered after two weeks to a group outside the study sample, consisting of **44 female students**. Pearson’s correlation coefficient was calculated between their scores on both administrations.

In addition, internal consistency reliability was assessed using **Cronbach’s alpha** coefficient. **Table 8** presents the internal consistency coefficients according to Cronbach’s alpha, as well as the test–retest reliability coefficients for each domain and for the instrument as a whole.

Table (8): Cronbach’s Alpha Internal Consistency and Test–Retest Reliability Coefficients for the Domains and Total Score of the Perceived Social Support Scale

Domain	Test–Retest Reliability	Internal Consistency (Cronbach’s Alpha)
Family	0.84	0.79
Friends	0.87	0.76
Significant Others	0.85	0.77
Total Score	0.88	0.84

- Health Behavior Scale

The Health Behavior Scale is a psychological scale that was developed by Al-Samadi, Ahmad Abdul-Majid and Al-Samadi, Muhammad Abdul-Ghafour (2011, p. 84) in a rigorous way so that it would be valid and reliable regarding counseling and behavioral psychotherapy. As both a diagnostic and therapeutic tool, it helps in data collection capable of being a resource to plan and design psychological counseling programs. In addition, it is a diagnostic tool which mental health professionals, public health professionals, and psychological and social workers can use to determine a student’s psychological issues, and then treat them accordingly.

Psychometric Properties of the Scale

• Validity

A. Construct Validity:

The researchers performed a confirmatory factor analysis to check the scale's validity, specifying the number of factors (N4) as four using the Principal Components method with Varimax rotation, as the dimensions are independent from one another [29]. If an item loaded on more than one factor, it was assigned to the factor with the largest loading.

The factor analysis indicated the presence of four factors, detailed in the following.;

The comparison of the factors achieved from the analysis, and the theoretical factors that the scale was developed on showed an over 80% similarity with a few items moving from one factor to another. Preliminary version of the scales were remove of items with less than 0.20 loadings on all factors. The other 46 items had a correlation with total score > 0.29, indicating that the scale is a valid measurement of the construct. It also suggested that these four factors together accounted for 32% of the variance (KMO = 0.865, df = 14, significance = 0.000).

Table (9): Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	7.520	16.711	16.711	7.520	16.711	16.711	5.101	11.336	11.336
2	2.893	6.429	23.141	2.893	6.429	23.141	3.348	7.439	18.776
3	2.546	5.695	28.799	2.546	5.659	28.799	3.150	6.999	25.774
4	1.520	3.379	32.178	1.520	3.379	32.178	2.882	6.404	32.178

So also, reached reasonable and acceptable correlation coefficients of items with their belonging dimensions.

B. Discriminant Validity:

To confirm the discriminative ability of the scale items, greater than 27% of the respondents on the scale were compared to those, less than 27% of the respondents on them. ITEM RESULTS The results showed that all items had a high discriminatory ability. They further hypothesized that students with a typical/average or below-average health level would perform worse than good health level peers, with statistical significance (77). To test this hypothesis, we further calculated the mean and standard deviations of their scores among the full scale.

Table (10): Means and Standard Deviations of Students' Scores by Variables

Independent Variable	Levels	Mean	Standard Deviation
General level of health	Very good	2.798	0.42
	Average	2.540	0.46
Presence of illness	No	2.763	0.43
	Yes	2.636	0.45
Average monthly family income	1–300 (Low)	2.762	0.44
	301–800 (Medium)	2.756	0.43
	801 or more (High)	2.738	0.43

A three-way analysis of variance (ANOVA) was performed on the means according to health status, economic status and whether students suffered from any disease. Table 10 demonstrates that participants with a higher health level achieved significantly higher scores on that scale than individuals with moderate and low health level. This confirms the hypothesis of the strength of discrimination property of the scale.

Scale Reliability

To evaluate the internal consistency of the overall scale and subdimensions hence the data was examined for the following coefficients:

Figure A: Cronbach's Alpha for the overall scale and subdimensions

The findings revealed that the scale had a high level of internal consistency (Cronbach's $\alpha = 0.87$) Given the internal consistency levels of the subdimensions: respectively 0.84, 0.74, 0.75 and 0.68, levels can be assessed as acceptable. The lower alpha coefficient associated with the fourth dimension is explained by the fact that this dimension included only eight items.

B. Test–retest reliability:

In order to check the external reliability of the instrument, the final version was given to a reliability sample of 54 male and female students from Faculty of Education, Yarmouk University in Jordan. The scale was then re-administered two weeks later to the same group. We calculated Pearson correlation coefficients between the two administrations for the overall scale and for its subdimensions. Results: The overall scale had correlation coefficients of 0.79, 0.81 for the first dimension, 0.79 for the second, 0.75 for the third and 0.78 for the fourth. Such values are regarded appropriate for the practical application of research.

2.4 – Statistical Methods Used

To assess the level of perceived social support and level of health behaviour among the study participants, means and standard deviations were calculated.

-Pearson's correlation coefficient was the test with which the relationship between the perceived social support and health behavior level of participants were analyzed.

-The effect of perceived social support on health behavior was analyzed using simple linear regression analysis.

-ANOVA: Type III Sum of Squares for regression coefficient of overall perceived social support on health behavior

-Multiple regression analysis of factors of perceived social support on health behavior

3- Results and Discussion

3.1- Results:

- Level of Perceived Social Support among the Study Participants

Table (11): Level of Perceived Social Support among Study Participants

Number of Scale Items	Number of Participants	Theoretical Mean of the Scale	Mean of Participants' Responses	Standard Deviation	t-value	p-value
12	112	36	41.68	9.81	6.13	0.000000014 (Statistically significant)

Results of the Perceived Social Support Scale according to table 11, the mean score of participants was 41.68 higher than theoretical mean of the scale (36) ($t = 6.13$, $p < 0.001$). This greater average means that participants consider themselves receiving high perceived social support from their environment (family, friends, significant others). This shows a largely favorable view of the support they experience in their lives.

This higher level of perceived social support is a positive signal that could be used to further explore the association between social support and health behavior adherence in chronic disease patients.

- Level of Health Behavior among the Study Participants

Table (12): Level of Health Behavior among Study Participants

Number of Scale Items	Number of Participants	Theoretical Mean of the Scale	Mean of Participants' Responses	Standard Deviation	t-value	p-value
44	112	132	162.46	26.71	12.07	0.001 (Statistically significant)

According to the results shown in Table 12, the average Health Behavior Scale score of participants was 162.46, which is significantly more than the theoretical mean of 132, with a statistically significant difference ($t = 12.07$, $p < 0.001$). Such high score means that the sample shows high compliance with health practices in their daily basis.

These data suggest a healthy self-awareness among participants regarding the importance of health-promoting behaviors (e.g. self-care; medication adherence; attention to nutrition, and social interaction). This increased score could also result from an above-average level of health consciousness or favorable environmental determinants conducive to the behaviors among participants.

Nature of the Relationship between Perceived Social Support and Health Behavior

Table (13): Nature and Significance of the Relationship between Perceived Social Support and Health Behavior

Variable	Correlation Coefficient (r)	Mean of Participants' Responses	Standard Deviation	p-value
Perceived Social Support	0.375	41.68	9.81	0.001 (Statistically significant)
Health Behavior	—	162.46	26.71	—

the outcomes reported in Table 13 reveals that the Pearson correlation coefficient was $r(39) = 0.37$ and the significance level was ($p = 0.001$) which confirm the moderate degree of positive correlation. That is, at higher levels of perceived social support, trial participants were also more likely to engage in health-promoting behaviours.

Presentation of the Simple Regression Coefficient

Table (14): Simple Linear Regression Coefficient for the Effect of Perceived Social Support on Health Behavior

Number of Participants	Dependent Variable	Independent Variable	Intercept	Regression Coefficient (B)	Standard Error	t-value	p-value
112	Health Behavior	Overall Perceived Social Support	119.961	1.02	0.241	4.237	0.000
Coefficient of Determination (R^2)							
0.1404		14%					

Simple linear regression analysis used to predict health behavior based on the overall perceived social support that the individual report was shown in Table 14. A total of 112 participants were included in the analysis, independent variable was health behavior, and dependent variable was overall perceived social support.

For the intercept, with overall perceived social support level = 0, the expected score on Health Behaviour Scale was 119.961. The regression coefficient (B) was 1.02, meaning that with every increase of one point in the overall perceived social support, there is an increase of 1.02 points of health behavior score, indicating a direct and positive effect.

The t-value was 4.237 (rather large: the significance of the effect of perceived social support on health behavior is unlikely to be random). Associated p-value ($p = 0.000$) stating that is well within the statistically significant limit ($p < 0.05$) making the result reliable and assuring strong relationship statistically between the two variables.

Overall perceived social support significantly and positively explained variance in health behaviour in a moderate manner according to the regression results validated. Additionally, the R^2 coefficient value of 0.1404 means that the variance of health behavior in participants could only be 14% explained by the regression model and perceived social support—including the three dimension—has a limited effect in predicting health own behavior.

Analysis of Variance for the Regression Coefficient of Overall Perceived Social Support on Health Behavior

Table (15): ANOVA for the Regression Coefficient of Overall Perceived Social Support on Health Behavior

Source	Degrees of Freedom (df)	Sum of Squares (SS)	Mean Square (MS)	F-value	p-value
Regression Model (Overall Perceived Social Support)	1	11,107.180	11,107.180	17.951	0.000
Residual (Error)	110	68,060.677	618.733	—	—
Total	111	79,167.857	—	—	—

Simple linear regression analysis used to predict health behavior based on the overall perceived social support that the individual report was shown in Table 15. A total of 112 participants were included in the analysis, independent variable was health behavior, and dependent variable was overall perceived social support.

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Multiple Regression Analysis of the Components of Perceived Social Support on Health Behavior

Table (16): Multiple Regression Coefficients for the Components of Perceived Social Support Predicting Health Behavior

Indicator	Number of Participants	Dependent Variable	Independent Variables	Intercept	Family Support t (B)	Friends Support t (B)	Others' Support t (B)	Std. Error (Family)	Std. Error (Friends)
Value	112	Health Behavior	Family Support, Friends Support, Others' Support	119.214	7.791	0.72	3.369	2.458	2.151
Indicator	Std. Error (Others' Support)	t-value (Family Support)	t-value (Friends Support)	t-value (Others' Support)	p-value (Family Support)	p-value (Friends Support)	p-value (Others' Support)	95% CI (Family Support)	95% CI (Friends Support)
Value	1.969	3.17	0.335	1.711	0.002	0.739	0.09	2.92 to 12.662	-3.543 to 4.983
Indicator	95% CI (Others' Support)	Partial R ² (Family Support)	% (Family Support)	Partial R ² (Friends Support)	% (Friends Support)	Partial R ² (Others' Support)	% (Others' Support)	—	—
Value	-0.534 to 7.272	0.0850	8.50%	0.0010	0.10%	0.0264	2.64%	—	—

Table 16: Results of multiple regression analysis regarding the predictive power of three dimensions (family, friends, and others) of perceived social support on health behavior of people. Sociodemographic characteristics of the 112 individuals for whom the analysis was carried out.

The intercept value (β_0) = 119.214 was interpreted as the mean score of health behavior when the three dimensions of support are set to zero, the level always used in interpretation as an important referential point. About the regression coefficients (B), the highest was the coefficient of family support = 7.791, meaning every increase of 1 point in family support resulted in a 7.79-point health behavior score increase. So this indicates how positively this dimension is swaying.

On the contrary, the effect of friends support was almost negligible ($B = 0.72$) with a low t (0.335) and high p (0.739), this dimension was therefore not significant, and does not modify the explanation of health behavior.

Another dimension of support from others was moderate, $B=3.369$ $t=1.711$. RELEVANT CONTENT The corresponding p -value (0.09) approaches but does not cross the conventional null-hypothesis significance threshold of 0.05. This would imply that the effect is not statistically significant in a strict sense, though it is significant enough to be noted and discussed.

These are in line with the 95% confidence intervals: confidence interval for family support (2.92 to 12.66) does not include zero, thus supports the significant effect statistically, whereas intervals for friends' support and others' support include 0 that refutes their case on the bootstrap analysis test.

The results also reveal that the family support dimension alone explains 8.5% of the variance in health behavior, while others' support only 2.64%, and friends' support has an almost negligible statistical effect (0.1%).

3.2- Discussion

In a specific context, the current study found that the study subjects had the higher level of perceived social support, which is similar with what found in previous research (Uchino, 2009; Abe et al. [10], as chronic diseases provide one with social support. The high level could be due to the variety of sources of support (like family/upbringing, friends, etc.) This could also be related to demographic variables, like educational level and marital status, as a large proportion of participants reported to be married and thus could receive social support from a spouse or children, while another proportion of seniors were older adults, who may receive support from other younger family members or friends.

Meanwhile, the mean score of health behavior in studied subjects was more than the theoretical mean in a statistically significant manner. This may be due to their relatively high health knowledge, as well as some social factors, such as the higher levels of education and the relatively higher number of participants at a middle age found [63], which also indicates greater interest in health, a finding in general agreement with the study by Lederer et al. (2025). The prevalence of going to the doctor often with a sizeable segment of the sample (40.2%) appear to be compliance with preventive behavior.

Also health behavior was positively correlated with perceived social support in the study with a significant level. Such a motivational impact of social support exposure on the uptake of health promoting behaviours (Gallant 2003; Fisher et al. 2010) is consistent with such a finding. One potential reason for this relationship is that individuals who feel supported by their social environment have a domain for implementing beneficial health strategies.

In the simple regression, perceived social support (from family and friends) accounted for 13% of the variability in predicting health behavior among subjects. This is consistent with the findings of Chunni Lin et al. These were in line with a study among aging people with chronic illnesses that found social support was responsible for about 14% of the variation in self-management behavior and the improvement of reciprocity (Gros et al. 2025). This

fraction is small, indicting that the sole promotion of health behavior is not significantly linked with the view of social support by chronic sicknessed people.

In addition, the multiple regression showed that only family support dimension could significantly predict health behavior from friends' support or others' support. The individual support of family members who are near and engage in daily life with him/her could probably be more effective. In comparison, social support related to support from friends and others had weak and not-crime effects possibly indicating these forms of support are fleeting or even unsustained and not invincible toward behavioral defense against targeted problem behavior.

This mitigates the suggestion that social support should be reserved for more health-directed goals only and not oriented toward general or purely emotional support (Witts et al., 2024). In other words, social support should be transformed into acts that improve patient adherence to treatment or a healthy lifestyle, otherwise, it is not effective.

4- Conclusion

Although perceived social support is a component of health behavior for people living with chronic illnesses, the findings of this study demonstrated that it is inadequate, in its broad form—for family, friend, or any source—to improve health behavior by itself. The simple perception of having someone near to help does not, per sé, translate into adopting a healthy lifestyle unless such help is targeted, aware of the specific nature of the illness and capable of following the patient in the details of daily life and health challenges.

The social environment surrounding the chronic illness patient was shown to have few actors able to push the patient towards the health behaviors consistent with their particular chronic condition. Well-intentioned social support efforts aimed at improving health may do so to a limited extent due to a relatively poor health awareness and may in some cases push the patient to develop some unhealthy behaviors—and even worse when the social support reinforces neglect, reliance and dependency by attributing the recovery of the patient to non-medical factors, pressing further with traditional remedies, or other practices which are socially and culturally legitimized but do not clearly favour healthy behaviors in chronic ill patients.

Perceived social support is rendered ineffective and ill-targeted when those surrounding the patient—albeit with good intentions—are not well-versed in the minutiae of health information and the situation at hand, which is frequently the case among the environment of a chronic illness stricken individual. Their lack of health literacy makes them unable to identify the actual needs of the patient that ultimately support with general or emotional support rather than specific and targeted that perhaps measures to the needs for behaviors change.

- Recommendations

- The development of precise tools to measure perceived social support related to health behavior, taking into account the quality of support, its source, and its alignment with the nature of the chronic illness, rather than relying solely on general measurements.
- Enhancing the health and psychological awareness of those actively involved in providing social support (family, friends, others) through workshops, media programs, and training courses focused on how to deliver effective and purposeful support.
- Advocating for the integration of the concept of perceived social support into basic healthcare programs.

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