

A Sociological Explanation of Health-Oriented Lifestyle among Women in Mashhad

Shahrzad. Bahadori Marghzar¹, Majedeh. Gholipour^{1*}, Abolghasem. Heydarabadi¹

¹ Department of Sociology, Bab.C., Islamic Azad University, Babol, Iran

*Correspondence: majedeh.gholipour@iau.ac.ir

Article type:
Original Research

Article history:
Received 26 May 2026
Revised 03 June 2026
Accepted 01 September 2026
Initial Publish 10 September 2026
Published online 01 May 2027

ABSTRACT

A health-oriented lifestyle, as a set of behavioral patterns that promote health, plays a fundamental role in women's quality of life. The present study aimed to provide a sociological explanation of health-oriented lifestyle among women in Mashhad and to identify the relative contributions of cultural, social, media-related, and structural factors influencing it. This study employed a cross-sectional survey design, and data were collected from 384 women over the age of 20 residing in Mashhad using stratified sampling. The research instrument was a structured questionnaire with confirmed reliability (Cronbach's alpha > .80). Data were analyzed using simple and multiple linear regression analyses and structural equation modeling (SEM) in SPSS 26 and AMOS 24. The results of multiple regression analysis indicated that six variables—socioeconomic status, cultural capital, religiosity, social media use, social capital, and social support—collectively explained 86.3% of the variance in health-oriented lifestyle ($R^2 = .863$, $F = 394.25$, $p < .001$). Social capital was the strongest predictor in the model ($\beta = .382$), followed by social support ($\beta = .231$) and social media use ($\beta = .158$). In the structural equation model, the coefficient of determination was .88, and social media use exhibited the strongest direct effect, with a path coefficient of .638. Cultural capital ($\beta = .271$) and social support ($\beta = .209$) ranked next in terms of their effects. The health-oriented lifestyle of women in Mashhad is a multidimensional and hybrid phenomenon in which social capital functions as a contextual foundation, while media and cultural capital operate as modern driving forces. Women's health policymaking should therefore simultaneously focus on strengthening traditional social networks and strategically utilizing the capacities of new media.

Keywords: health-oriented lifestyle, social capital, cultural capital, social support, religiosity, social media

How to cite this article:

Bahadori Marghzar, Sh., Gholipour, M., & Heydarabadi, A. (2027). A Sociological Explanation of Health-Oriented Lifestyle among Women in Mashhad. *Mental Health and Lifestyle Journal*, 5(3), 1-18. <https://doi.org/10.61838/mhlj.304>

Introduction

Health-oriented lifestyle has become an increasingly important concept in contemporary sociology of health because patterns of health behavior are not formed solely through individual choice or biomedical knowledge; rather, they are embedded in social structures, cultural resources, interpersonal networks, media environments, value systems, and unequal distributions of economic and symbolic capital. In its broadest sense, a health-oriented lifestyle refers to relatively stable patterns of action through which individuals seek to preserve, improve, or restore their physical, psychological, and social well-being. These patterns may include appropriate nutrition, regular physical activity, preventive health behaviors, stress management, responsible use of health services, attention to personal and environmental hygiene, avoidance of health-risk behaviors, and engagement with reliable health information. From a sociological perspective, however,

such behaviors are not simply outcomes of personal motivation. They are socially patterned practices that reflect individuals' positions within systems of inequality, their access to material and cultural resources, the norms and expectations prevailing in their social environment, and the opportunities made available through social relationships and institutions. Accordingly, the study of health-oriented lifestyle requires attention not only to behavioral outcomes but also to the social processes through which such behaviors become possible, desirable, legitimate, and sustainable (1, 2).

The growing attention to lifestyle in health research reflects a broader transition from narrowly biomedical explanations of health toward multidimensional frameworks that recognize the interaction between individual behavior and social context. Lifestyle has sometimes been used imprecisely in health psychology and public health, yet contemporary scholarship increasingly treats it as a complex configuration of behaviors, meanings, social routines, and identity practices rather than a collection of isolated habits (1). This conceptualization is particularly important because individuals often adopt or reject health-promoting behaviors as part of broader ways of living that are shaped by family expectations, peer norms, educational experiences, cultural preferences, social class, religious values, and mediated representations of the body and well-being. International evidence also indicates that healthy lifestyles vary considerably across populations and over time, reflecting differences in social environment, cultural expectations, and institutional contexts (3, 4). Therefore, an adequate sociological explanation of health-oriented lifestyle must move beyond the assumption that health behavior is entirely a matter of personal responsibility and examine the structural and relational conditions under which health-promoting choices are produced.

Women constitute a particularly important population for the sociological study of health-oriented lifestyles. In many societies, women simultaneously manage occupational, familial, caregiving, reproductive, and emotional responsibilities, and these multiple roles may directly affect the time, resources, and autonomy available for health-promoting practices. Women's health behaviors may also exert effects beyond the individual level because women frequently influence household nutrition, children's health practices, family care routines, and patterns of health service utilization. Consequently, women's health-oriented lifestyles are embedded within gendered social expectations and family structures as well as broader socioeconomic and cultural conditions. Research conducted among young women in Shiraz, for example, has demonstrated that health-oriented lifestyle is associated with a range of social and contextual factors, supporting the view that women's health behavior should be interpreted through a sociological framework rather than solely an individualistic one (5). Similarly, comparative research on mothers and daughters has indicated that the social determinants of health-oriented lifestyle may differ across generations, suggesting that social change, changing cultural norms, and differences in exposure to modern institutions and media can reshape women's health-related practices (6).

Socioeconomic status is among the most fundamental structural factors expected to influence a health-oriented lifestyle. Economic resources affect the affordability of nutritious food, access to recreational facilities, residential quality, preventive healthcare, transportation, and opportunities for leisure and physical activity. Educational attainment can additionally affect health literacy, the ability to evaluate health information, and awareness of long-term health risks. Occupational status may determine exposure to stress, time constraints, social security, and access to organizational health resources. These dimensions jointly shape the opportunity structure within which health choices are made. Evidence from different social

settings has shown that economic capital interacts with other forms of capital in shaping dietary patterns and physical activity (7). Research on rural residents has likewise demonstrated that capital endowment is related to health information literacy and healthy dietary behaviors, emphasizing that access to health-promoting knowledge is itself socially stratified (8). In the Iranian context, meta-analytic evidence has also identified socioeconomic and demographic variables among the recurring determinants of health-oriented lifestyle, although their effects vary across populations and research settings (2). Findings among university students further suggest that demographic characteristics are associated with differences in health-oriented lifestyle, reinforcing the need to consider structural heterogeneity within populations (9).

Beyond economic resources, cultural capital provides a particularly useful sociological framework for understanding differences in health behavior. Cultural capital encompasses knowledge, competencies, dispositions, preferences, and embodied orientations that enable individuals to navigate social institutions and interpret culturally valued forms of information and behavior. Applied to health, cultural capital can influence the ability to recognize legitimate health knowledge, understand medical recommendations, distinguish credible information from misinformation, and transform abstract awareness into everyday practices. Individuals with higher levels of cultural capital may be more familiar with preventive approaches to health, more willing to participate in organized physical activity, and more capable of interpreting nutrition and health messages. Empirical studies in Iran have reported a significant relationship between cultural capital and health-oriented lifestyle, particularly among adult populations and women (10, 11). International evidence similarly indicates that embodied cultural capital is associated with health behaviors such as diet and physical activity, although these associations may be conditioned by economic and social resources (7). Therefore, cultural capital should not be conceptualized merely as educational achievement; it represents a broader set of socially acquired competencies that can facilitate health-oriented choices.

Social capital constitutes another central dimension in a sociological explanation of health-oriented lifestyle. Social capital generally refers to resources embedded in social relationships, including trust, reciprocity, participation, shared norms, network connections, and access to collective support. These resources may shape health behavior through several mechanisms. Social networks can transmit health information, normalize preventive behavior, encourage physical activity, facilitate access to care, and provide emotional reinforcement for sustaining difficult behavioral changes. Trust and participation can also influence individuals' willingness to engage with institutions and health-related community initiatives. Conversely, weak social integration, limited trust, and social isolation may reduce access to both informational and emotional resources. The relationship between social capital and health behavior is therefore not peripheral but potentially foundational, because health-related practices are often learned and maintained through relational environments. Research on sociocultural determinants of health-oriented lifestyle in Iran has consistently pointed toward the importance of social relationships, social participation, and collective resources (2, 12).

Closely related to social capital, but analytically distinct from it, is social support. Social support refers more specifically to the emotional, informational, evaluative, and instrumental assistance received from significant others, family members, peers, and social networks. Such support can facilitate health-promoting behavior by reducing perceived stress, increasing psychological security, providing practical assistance, and reinforcing motivation. In women's everyday lives, social support may be particularly important because

responsibilities associated with employment, household management, childcare, and caregiving can constrain opportunities for self-care. Supportive relationships may alleviate these constraints by redistributing responsibilities or providing encouragement for healthy behaviors. Research on urban resilience has highlighted the importance of social support in relation to health-oriented lifestyle, suggesting that supportive social relations contribute not only to individual health behavior but also to broader capacities for adaptation and well-being (13). Differences in health-oriented lifestyles among different social and age groups may likewise reflect variation in the quantity and quality of available support networks (14).

Religiosity also warrants consideration in the sociological analysis of health-oriented lifestyle, particularly in societies where religious beliefs and practices remain important sources of moral regulation, identity, social participation, and everyday meaning. Religiosity may influence health behavior through norms concerning bodily discipline, avoidance of harmful behavior, moderation, responsibility toward the self, and participation in communal networks. Religious involvement can also provide social support, collective identity, and psychological resources that indirectly affect health-related practices. However, the relationship between religiosity and health-oriented lifestyle is unlikely to be uniform. Its effects may differ according to the dimensions of religiosity measured, the social context, the extent to which religious values are integrated into everyday practices, and the interaction between religious and modern lifestyle orientations. Research on lifestyle and contemporary domestic life in Mashhad has emphasized the significance of value and ritual dimensions in shaping everyday lifestyles, demonstrating that religious and cultural values remain relevant to the organization of daily practices in the city (15). Studies of sociocultural determinants of health lifestyle also suggest that normative and value-related orientations should be incorporated into explanatory models rather than treated as peripheral variables (12).

At the same time, contemporary lifestyles are increasingly constructed within digital and media environments. Social media platforms have transformed how individuals obtain health information, observe lifestyle models, compare themselves with others, construct identities, and participate in communities organized around health, fitness, diet, beauty, and well-being. Digital platforms can expand access to health knowledge and expose users to preventive information, expert advice, peer experiences, and motivational content. Research in Iran has shown that media consumption is associated with citizens' health-oriented lifestyles, indicating that media environments can function as important agents of lifestyle formation (16). More recent research has specifically examined how the type of virtual social network use influences the choice of a health-oriented lifestyle, further underscoring the growing relevance of digital media in behavioral and cultural processes (17). Social networks may also interact with other determinants of lifestyle, as demonstrated by research proposing a health-oriented academic lifestyle model in which social networks play a moderating role (18).

Nevertheless, the influence of social media is not uniformly beneficial. Digital networks also expose users to misinformation, unrealistic body ideals, commercialized health claims, lifestyle comparison, compulsive use, and conflicting behavioral norms. Consequently, the same platforms that disseminate health-promoting information can also contribute to psychological stress, distorted risk perceptions, or unhealthy lifestyle patterns. Studies examining the harmful effects of social networks have emphasized their potential consequences for lifestyle and beliefs, demonstrating the need for a differentiated interpretation of media effects rather than an assumption that digital exposure automatically improves health behavior (19).

Research on Instagram and identity formation likewise shows that social media can participate actively in shaping lifestyles and self-conceptions, particularly among younger users (20). This dual character of social media suggests that its sociological significance lies not merely in frequency of use but in the ways digital practices intersect with cultural capital, identity, social networks, and access to credible information.

Health-oriented lifestyle is therefore best understood as the product of interaction among multiple forms of social advantage and social influence. Economic resources may facilitate access to health-promoting opportunities, but their effects can be strengthened or constrained by cultural competencies. Social networks may provide valuable information, but their usefulness depends on trust, quality, and the type of resources circulating within them. Media can democratize access to health information while simultaneously reproducing inequalities in information literacy and reinforcing problematic norms. Religiosity can offer behavioral guidance and social integration while interacting with generational and cultural changes. This multidimensionality is consistent with international research showing that healthy living is culturally embedded and cannot be separated from broader systems of meaning and social organization (4). It also aligns with evidence that health-promoting lifestyles vary according to educational and disciplinary background, indicating that different social environments generate different configurations of knowledge, motivation, and behavior (21).

The spatial and urban context in which lifestyles are practiced is also relevant. Lifestyle is partly materialized through the organization of housing, neighborhoods, accessibility, and everyday urban routines. In Mashhad, transformations in the spatial organization of residential environments have been associated with changes in contemporary lifestyle, indicating that lifestyle practices are embedded in changing forms of urban life (22). The city is characterized by substantial socioeconomic diversity, differences in residential patterns, rapid expansion of digital communication, and coexistence of traditional, religious, and modern cultural orientations. These characteristics make Mashhad a particularly relevant setting for examining how structural, cultural, relational, and media-related factors jointly influence women's health behaviors. The simultaneous presence of strong religious traditions, expanding educational opportunities, digital media penetration, and marked socioeconomic differentiation creates a social environment in which health-oriented lifestyles may reflect hybrid combinations of traditional and modern orientations.

The importance of studying these relationships among women in Mashhad is further strengthened by findings from Iranian studies conducted in other cities and populations. Research among women in Shiraz has demonstrated that health-oriented lifestyle is associated with social factors, while studies in Damghan have emphasized the role of cultural capital (5, 10, 11). Research in East Azerbaijan has demonstrated the relevance of media, and comparative research in Sirjan has revealed generational differences in the social determinants of lifestyle (6, 16). Studies among Iranian and Afghan older adults have shown that health-oriented lifestyle can vary across sociocultural groups, underscoring the influence of population context (14). Meta-analytic evidence also indicates that multiple social, demographic, and psychological variables contribute to health-oriented lifestyle across Iranian studies rather than any single predictor accounting for the phenomenon (2). Together, these findings support the need for models that integrate several explanatory domains simultaneously.

Another important consideration is that lifestyle itself can function as a mechanism through which broader social processes are expressed. Lifestyle choices communicate social identity, cultural distinction, values, and belonging. Health-oriented behavior may therefore have symbolic as well as instrumental meanings. Participation in fitness, dietary choices, engagement with health information, or the use of preventive services may reflect not only concern for health but also educational orientation, class-based dispositions, identity projects, and membership in particular social networks. This interpretation is compatible with approaches emphasizing conflict management and adaptive strategies within lifestyle domains, which suggest that lifestyle is negotiated within changing social contexts rather than simply adopted as a fixed behavioral pattern (23). From this perspective, women may combine inherited cultural expectations with new health norms promoted through education, digital media, and modern consumer environments, resulting in hybrid lifestyle configurations.

The changing character of healthy living also raises important questions about the balance between continuity and transformation across generations. International longitudinal and comparative research has demonstrated that healthy lifestyle patterns can change over time and differ across cultural settings (3). In rapidly changing societies, younger generations may be particularly influenced by digital culture, individualized health discourses, and globalized ideals of fitness and well-being, whereas older generations may remain more closely tied to familial, religious, and community-based norms. Yet these orientations should not be treated as mutually exclusive. Health-oriented lifestyle may emerge precisely through the combination of traditional social support, religious values, cultural resources, and modern media exposure. This hybrid character is especially plausible in urban contexts such as Mashhad, where longstanding cultural and religious institutions coexist with expanding digital networks and changing forms of urban consumption.

Despite the expanding literature, several gaps remain. Many existing studies examine only one or two determinants of health-oriented lifestyle, such as cultural capital, media use, socioeconomic status, or social support. Others focus on particular age groups, students, older adults, or residents of specific cities, limiting the extent to which findings can be generalized to broader populations of urban women. Moreover, associations identified through separate regression analyses may not fully reveal the relative contribution of multiple predictors when they are modeled simultaneously. Structural equation modeling offers an important advantage in this regard because it permits the estimation of multiple relationships within an integrated theoretical framework and provides an assessment of the overall correspondence between the hypothesized sociological model and the observed data. Given evidence that lifestyle is simultaneously associated with cultural, economic, relational, and informational resources, an integrated model is necessary to determine which dimensions exert the greatest direct influence and how strongly the combined model explains variation in women's health-oriented lifestyle (7, 8).

Furthermore, the increasing importance of social networks in everyday life creates a need to reconsider the relative weight of traditional and contemporary determinants of health behavior. Social capital and social support represent more traditional relational mechanisms through which individuals obtain resources and reinforcement, whereas social media represents a newer and increasingly influential environment for exposure to information, norms, identities, and lifestyle models. Cultural capital may mediate individuals' ability to evaluate these competing sources of influence, while socioeconomic position may determine access

to both offline and online health resources. Religiosity adds a normative dimension that may reinforce or reshape behavioral choices. Examining these variables together can therefore illuminate whether women's health-oriented lifestyle is primarily structured by material position, embedded social relations, cultural competencies, religious orientations, or media exposure. Such an analysis is particularly valuable for designing health policies that move beyond generic behavioral recommendations and address the social conditions that enable or constrain healthy living. Accordingly, the aim of the present study was to provide a sociological explanation of health-oriented lifestyle among women in Mashhad by examining the relative effects of socioeconomic status, cultural capital, religiosity, social media use, social capital, and social support within an integrated explanatory model.

Methods and Materials

The present study employed a cross-sectional survey design. The statistical population consisted of all women over the age of 20 residing in Mashhad. Using Cochran's sample size formula and considering a 5% margin of error, the sample size was determined to be 384 participants. Proportionate stratified sampling was conducted based on urban residential areas categorized as low-, medium-, and high-value in terms of housing prices in order to adequately represent the socioeconomic diversity of the population. Data were collected using a structured questionnaire that measured the study variables, including health-oriented lifestyle (six dimensions), cultural capital (three dimensions), religiosity (three dimensions), social media use (two dimensions), social capital (three dimensions), social support (three dimensions), and socioeconomic status. The validity of the instrument was confirmed through content validity based on expert judgment and confirmatory factor analysis, while its reliability was established using Cronbach's alpha coefficients ranging from .82 to .95. Data were analyzed using SPSS 26 and AMOS 24. After examining the regression assumptions, including normality, linearity, absence of multicollinearity, and independence of errors, simple and multiple linear regression analyses and structural equation modeling were employed to test the study hypotheses.

Findings and Results

A total of 384 women aged over 20 years residing in Mashhad participated in the study. Examination of the demographic characteristics indicated that the sample represented a relatively broad range of age, educational, marital, occupational, and socioeconomic groups. The participants' mean age was 38.64 years ($SD = 10.27$), with ages ranging from 21 to 68 years. In terms of age distribution, 96 participants (25.0%) were 20–29 years old, 124 (32.3%) were 30–39 years old, 92 (24.0%) were 40–49 years old, and 72 (18.8%) were 50 years of age or older. Regarding marital status, 249 participants (64.8%) were married, 89 (23.2%) were single, 29 (7.6%) were divorced, and 17 (4.4%) were widowed. With respect to educational attainment, 71 participants (18.5%) had a high school diploma or lower level of education, 45 (11.7%) held an associate degree, 164 (42.7%) held a bachelor's degree, 87 (22.7%) held a master's degree, and 17 (4.4%) held a doctoral or professional degree. Occupationally, 104 participants (27.1%) were homemakers, 118 (30.7%) were employed in governmental or private organizations, 51 (13.3%) were self-employed, 53 (13.8%) were students, 26 (6.8%) were university professors or employed in academic positions, and 32 (8.3%) were retired or belonged to other occupational categories. In terms of the residential-area classification used as

an indicator of socioeconomic differentiation, 119 participants (31.0%) lived in relatively low-value residential areas, 166 (43.2%) lived in medium-value areas, and 99 (25.8%) lived in relatively high-value areas. Overall, the demographic distribution demonstrated sufficient heterogeneity across the major social strata included in the study and was consistent with the stratified sampling procedure employed to capture variation among women living in different socioeconomic contexts in Mashhad.

Table 1. Descriptive Statistics and Distributional Characteristics of the Study Variables (N = 384)

Variable	Mean	SD	Minimum	Maximum	Skewness	Kurtosis	Cronbach's α
Health-Oriented Lifestyle	3.71	0.58	1.83	4.94	-0.31	-0.18	.95
Cultural Capital	3.54	0.67	1.47	4.93	-0.24	-0.37	.89
Religiosity	3.68	0.72	1.33	5.00	-0.36	-0.21	.91
Social Media Use	3.76	0.74	1.25	5.00	-0.42	-0.29	.86
Social Capital	3.61	0.63	1.44	4.96	-0.28	-0.16	.93
Social Support	3.73	0.66	1.39	5.00	-0.39	-0.12	.92
Socioeconomic Status	3.42	0.71	1.40	5.00	-0.17	-0.34	.82

As presented in Table 1, the mean scores of the principal study variables were generally above the theoretical midpoint of the measurement scales. The mean score for health-oriented lifestyle was 3.71 (SD = 0.58), suggesting a relatively favorable overall level of health-oriented behavioral patterns among the women participating in the study. Among the independent variables, social media use had the highest mean score (M = 3.76, SD = 0.74), closely followed by social support (M = 3.73, SD = 0.66) and religiosity (M = 3.68, SD = 0.72). Social capital also showed a relatively high mean (M = 3.61, SD = 0.63), while cultural capital had a mean of 3.54 (SD = 0.67). Socioeconomic status had the lowest mean among the variables examined (M = 3.42, SD = 0.71), although its mean remained above the midpoint of the scale. The standard deviations indicated sufficient variability among participants and did not suggest excessive clustering of responses. Moreover, the skewness values ranged from -0.42 to -0.17 and the kurtosis values ranged from -0.37 to -0.12. Because all skewness and kurtosis coefficients were well within the commonly accepted range for approximate univariate normality, the distributions of the variables were considered suitable for parametric statistical analyses. The internal consistency coefficients were also satisfactory, with Cronbach's alpha values ranging from .82 for socioeconomic status to .95 for health-oriented lifestyle. Accordingly, the descriptive and psychometric findings supported the adequacy of the variables for subsequent correlation, regression, and structural equation modeling analyses.

Table 2. Multiple Linear Regression Analysis Predicting Health-Oriented Lifestyle from Sociocultural, Media-Related, and Socioeconomic Factors

Predictor	B	SE B	β	t	p	Tolerance	VIF
Constant	0.42	0.11	—	3.82	< .001	—	—
Socioeconomic Status	0.09	0.02	.101	4.21	< .001	.61	1.64
Cultural Capital	0.13	0.03	.137	4.89	< .001	.53	1.89
Religiosity	0.07	0.02	.076	3.03	.003	.68	1.47
Social Media Use	0.12	0.02	.158	5.67	< .001	.57	1.75
Social Capital	0.35	0.03	.382	11.96	< .001	.44	2.27
Social Support	0.20	0.03	.231	7.63	< .001	.49	2.04

Note. R = .929, R² = .863, adjusted R² = .861, F(6, 377) = 394.25, p < .001.

Table 2 presents the results of the multiple linear regression analysis conducted to determine the simultaneous contribution of socioeconomic status, cultural capital, religiosity, social media use, social capital, and social support to the prediction of health-oriented lifestyle. The overall regression model was statistically significant, $F(6, 377) = 394.25$, $p < .001$, and produced a multiple correlation coefficient of $R = .929$. The coefficient of determination was $R^2 = .863$ and the adjusted coefficient of determination was .861, indicating that approximately 86.3% of the variance in women's health-oriented lifestyle was jointly explained by the six predictor variables. This represents a substantial proportion of explained variance and demonstrates the considerable explanatory capacity of the proposed sociological model. Among the predictors, social capital emerged as the strongest predictor of health-oriented lifestyle ($\beta = .382$, $p < .001$), indicating that women who reported greater interpersonal trust, social participation, network connectedness, and access to relational resources were substantially more likely to report health-promoting lifestyle patterns. Social support was the second strongest predictor ($\beta = .231$, $p < .001$), demonstrating the importance of emotional, instrumental, and informational resources received through interpersonal relationships. Social media use also made a significant independent contribution to the model ($\beta = .158$, $p < .001$), suggesting that engagement with social media and exposure to health-related information within digital environments were associated with stronger health-oriented behavioral patterns. Cultural capital was another significant predictor ($\beta = .137$, $p < .001$), while socioeconomic status ($\beta = .101$, $p < .001$) and religiosity ($\beta = .076$, $p = .003$) also exerted statistically significant positive effects, although their relative contributions were smaller. Examination of multicollinearity diagnostics showed that tolerance values ranged from .44 to .68 and VIF values ranged from 1.47 to 2.27. These values were within acceptable limits and indicated that multicollinearity did not threaten the stability or interpretability of the regression coefficients. Taken together, the regression findings demonstrate that health-oriented lifestyle among women in Mashhad cannot be reduced to a single economic or individual characteristic; rather, it is jointly shaped by social resources, cultural competencies, religious orientation, digital-media engagement, and structural socioeconomic conditions.

Table 3. Goodness-of-Fit Indices for the Structural Equation Model

Fit Index	Obtained Value	Recommended Criterion	Fit Evaluation
χ^2/df	3.56	< 5.00	Acceptable
GFI	.901	> .90	Good
AGFI	.846	> .80	Acceptable
NFI	.938	> .90	Good
TLI	.935	> .90	Good
CFI	.954	> .90	Good
RMSEA	.082	< .08–.10	Acceptable

As shown in Table 3, the goodness-of-fit indices generally supported the adequacy of the proposed structural equation model. The ratio of chi-square to degrees of freedom (χ^2/df) was 3.56, which was below the criterion of 5.00 and therefore indicated an acceptable correspondence between the hypothesized model and the observed data. The goodness-of-fit index (GFI = .901) exceeded the recommended threshold of .90, indicating a satisfactory absolute fit. The adjusted goodness-of-fit index (AGFI = .846) was also above the minimum acceptable threshold of .80. Furthermore, the normed fit index (NFI = .938), Tucker–Lewis index (TLI = .935), and comparative fit index (CFI = .954) were all greater than .90, providing evidence of good incremental and comparative model fit. In particular, the CFI value of .954 indicated that the proposed

structural model represented a considerable improvement over the corresponding independence model. The root mean square error of approximation (RMSEA) was .082. Although this value was slightly higher than the more conservative threshold of .08, it remained within the acceptable range extending to .10 and therefore indicated an acceptable approximation of the model to the population covariance structure. Considering the fit indices collectively rather than relying on a single statistic, the structural equation model demonstrated an adequate-to-good overall fit. Consequently, the theoretical model specifying direct effects of socioeconomic status, cultural capital, religiosity, social media use, social capital, and social support on women's health-oriented lifestyle was considered empirically supported and sufficiently well fitted to permit interpretation of the estimated structural paths.

Table 4. Direct Effects of the Predictors on Health-Oriented Lifestyle in the Structural Equation Model

Structural Path	Unstandardized Coefficient (B)	SE	Critical Ratio	Standardized Coefficient (β)	p	Result
Social Media Use → Health-Oriented Lifestyle	0.469	0.056	8.359	.638	< .001	Supported
Socioeconomic Status → Health-Oriented Lifestyle	0.112	0.030	3.761	.098	< .001	Supported
Social Capital → Health-Oriented Lifestyle	0.086	0.027	3.151	.100	.002	Supported
Social Support → Health-Oriented Lifestyle	0.161	0.061	2.638	.209	.008	Supported
Religiosity → Health-Oriented Lifestyle	0.082	0.037	2.229	.103	.026	Supported
Cultural Capital → Health-Oriented Lifestyle	0.201	0.037	5.403	.271	< .001	Supported

The structural coefficients presented in Table 4 indicated that all six hypothesized direct paths to health-oriented lifestyle were positive and statistically significant. The structural model explained 88% of the variance in health-oriented lifestyle ($R^2 = .88$), demonstrating a high level of explanatory power. Social media use had the strongest standardized direct effect on health-oriented lifestyle ($\beta = .638$, $B = 0.469$, $SE = 0.056$, $CR = 8.359$, $p < .001$). Thus, after the simultaneous inclusion of the other sociocultural and structural factors in the model, greater social media use remained strongly associated with a more health-oriented lifestyle. This finding highlights the central position of contemporary digital environments in the acquisition, dissemination, and reinforcement of health-related knowledge and behavioral orientations among women. Cultural capital had the second strongest standardized effect ($\beta = .271$, $B = 0.201$, $SE = 0.037$, $CR = 5.403$, $p < .001$), indicating that access to cultural resources, competencies, and practices was positively associated with health-oriented behavioral choices. Social support also demonstrated a meaningful positive direct effect ($\beta = .209$, $B = 0.161$, $SE = 0.061$, $CR = 2.638$, $p = .008$), confirming that the availability of supportive interpersonal resources contributed independently to women's health-related lifestyles. Religiosity had a smaller but statistically significant positive effect ($\beta = .103$, $B = 0.082$, $SE = 0.037$, $CR = 2.229$, $p = .026$). Social capital also exerted a significant positive direct effect ($\beta = .100$, $B = 0.086$, $SE = 0.027$, $CR = 3.151$, $p = .002$), while socioeconomic status showed a significant standardized coefficient of $\beta = .098$ ($B = 0.112$, $SE = 0.030$, $CR = 3.761$, $p < .001$). Although the standardized direct effects of socioeconomic status, social capital, and religiosity were more modest than those of social media use, cultural capital, and social support within the structural model, their statistical significance demonstrates that each retained an independent contribution to the explanation of health-oriented lifestyle. The difference

between the relative importance of social capital in the multiple regression analysis and its direct coefficient in the structural equation model further indicates that the explanatory role of social resources may operate within a more complex network of relationships once measurement structures and simultaneous latent-variable relationships are taken into account. Overall, the SEM findings confirmed the multidimensional character of health-oriented lifestyle and showed that its strongest direct structural determinant was engagement with social media, followed by cultural capital and social support.

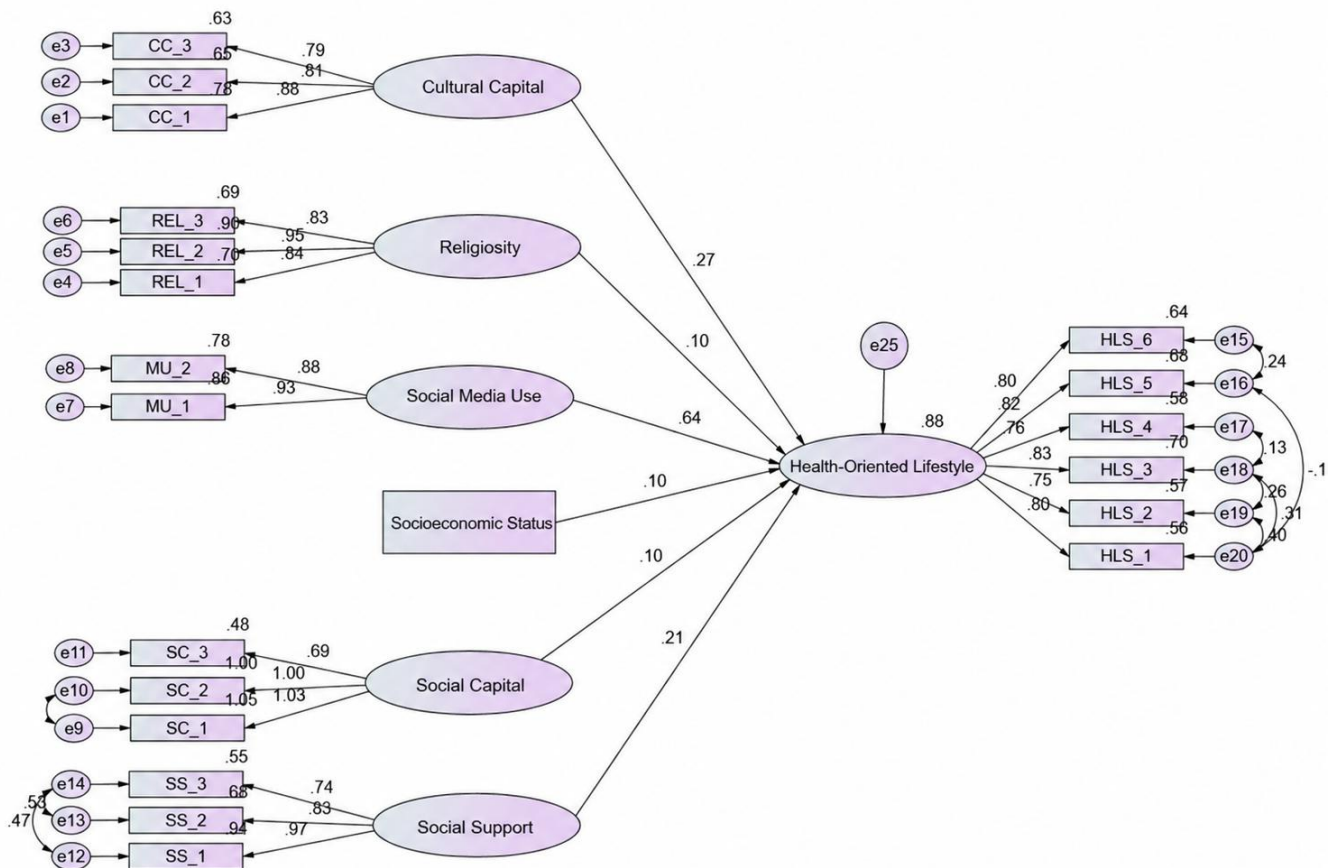


Figure 1. Structural Equation Model of the Sociocultural, Media-Related, and Socioeconomic Predictors of Health-Oriented Lifestyle among Women in Mashhad

Overall, the findings obtained from the descriptive analyses, multiple regression model, and structural equation model converged in demonstrating that health-oriented lifestyle among women in Mashhad is embedded in a multidimensional social context. The regression model showed that the combination of socioeconomic status, cultural capital, religiosity, social media use, social capital, and social support accounted for 86.3% of the observed variance in health-oriented lifestyle, whereas the structural equation model explained approximately 88% of its variance. The consistency of the overall explanatory power across the two analytical approaches strengthens the empirical support for the proposed sociological framework. At the same time, the relative weight of the predictors differed across the analytical models. Social capital emerged as the strongest predictor in the multiple regression analysis, whereas social media use displayed the largest standardized direct path in the structural equation model. Cultural capital and social support also maintained substantial roles, while socioeconomic status and religiosity demonstrated smaller but

statistically significant contributions. These findings collectively indicate that women's engagement in health-promoting behaviors is associated not merely with their material position, but also with their embeddedness in social networks, access to supportive relationships, possession of cultural resources, religious orientations, and participation in contemporary digital communication environments.

Discussion and Conclusion

The present study sought to provide a sociological explanation of health-oriented lifestyle among women in Mashhad by examining the effects of socioeconomic status, cultural capital, religiosity, social media use, social capital, and social support. The findings demonstrated that the proposed sociological model had substantial explanatory power. In the multiple regression analysis, the six predictor variables jointly explained 86.3% of the variance in health-oriented lifestyle, indicating that women's health-related practices are strongly embedded in their social, cultural, relational, and media environments. Social capital was the strongest predictor in the regression model, followed by social support and social media use. In the structural equation model, the explanatory power increased slightly, with the model accounting for 88% of the variance in health-oriented lifestyle. All six structural paths were statistically significant. Social media use had the strongest direct standardized effect, followed by cultural capital and social support, whereas religiosity, social capital, and socioeconomic status also showed significant positive direct effects. Collectively, these findings confirm that health-oriented lifestyle among women in Mashhad is a multidimensional social phenomenon that cannot be adequately explained through individual preferences or material resources alone.

One of the most important findings was the strong role of social capital. In the regression model, social capital emerged as the strongest predictor of health-oriented lifestyle. This result is consistent with sociological approaches that regard health behavior as embedded in social networks, interpersonal trust, participation, reciprocity, and access to relational resources. Women who are more strongly integrated into supportive and trusting networks may have greater access to health information, encouragement, normative reinforcement, and practical resources that facilitate health-promoting behaviors. The finding is consistent with Iranian research emphasizing the importance of sociocultural factors in shaping health-oriented lifestyle (2, 12). It is also theoretically compatible with evidence showing that different forms of capital jointly influence diet, physical activity, and other health-related practices (7). From this perspective, social capital acts not simply as an interpersonal resource but as a mechanism through which health-related norms and information circulate and become incorporated into everyday routines. In an urban context such as Mashhad, where family, kinship, neighborhood, religious, and friendship networks can remain highly influential, such relational embeddedness may provide an important foundation for women's health-oriented practices.

Social support also had a substantial positive effect on health-oriented lifestyle in both analytical models. In the regression model, it was the second strongest predictor, and in the structural model it retained a meaningful standardized direct effect. This finding indicates that women who perceive greater emotional, instrumental, and informational support are more likely to engage in healthier patterns of living. Social support may reduce psychological strain, facilitate coping with daily responsibilities, and make it easier for women to allocate time and resources to preventive behaviors, physical activity, healthy nutrition, and self-

care. This result aligns with research emphasizing the role of social support in relation to health-oriented lifestyle and broader adaptive capacities (13). It is also consistent with findings showing that health-oriented lifestyles vary across social groups partly because of differences in available interpersonal and collective resources (14). The significance of social support is particularly understandable among women, whose health behavior may be shaped by the balance between caregiving obligations and available assistance from family members and other close relationships.

Another central finding was the particularly strong direct effect of social media use in the structural equation model. Social media use had the largest standardized path coefficient among all predictors, indicating that digital environments now constitute a major arena in which health-related lifestyles are shaped. This finding is consistent with previous research showing a relationship between media use and health-oriented lifestyle among Iranian populations (16). It also supports findings suggesting that the type and pattern of virtual social network use can influence the adoption of a health-oriented lifestyle (17). Contemporary social media platforms provide rapid access to information about nutrition, exercise, mental health, disease prevention, body care, and self-management. They also expose users to peer models and lifestyle influencers, creating repeated opportunities for social comparison, imitation, and normalization of health-related practices. The observed effect is therefore understandable within a sociological framework in which digital media operate as agents of socialization that increasingly complement or compete with family, education, religion, and traditional community networks.

At the same time, the strong role of social media should not be interpreted as evidence that all forms of digital engagement are beneficial. Previous research has also highlighted the potentially harmful effects of social networks on beliefs and lifestyle patterns (19). Social media can simultaneously disseminate reliable health information and expose users to misinformation, commercialized wellness narratives, unrealistic body standards, and potentially harmful health practices. Research on Instagram and lifestyle formation likewise indicates that digital platforms play an active role in identity construction and the reproduction of lifestyle models (20). Therefore, the positive relationship observed in the present study may reflect the extent to which women use digital media as informational and motivational resources, but it also emphasizes the importance of media literacy. The findings suggest that social media should be considered a central component of contemporary health-oriented lifestyle rather than a peripheral communication tool.

Cultural capital was also identified as an important determinant, particularly in the structural equation model, where it had the second strongest standardized direct effect. This finding supports prior Iranian research that has explicitly demonstrated a significant association between cultural capital and health-oriented lifestyle (10, 11). Cultural capital can influence health behavior through knowledge, competencies, preferences, interpretive abilities, and dispositions that enable individuals to understand health information and transform it into practice. Women with greater cultural resources may be more likely to recognize the long-term value of preventive behavior, critically evaluate competing sources of health information, engage with formal health institutions, and adopt culturally valued forms of self-care. International evidence also supports the association between cultural capital and health-related behaviors such as diet and physical activity (7). Similarly, research linking capital endowment and health information literacy to healthy dietary behavior suggests that social inequalities in health are partly reproduced through unequal access to interpretive and informational resources (8).

The significance of cultural capital is especially important when considered alongside the strong effect of social media. Digital exposure alone does not guarantee informed health behavior; individuals require the cognitive and cultural competencies necessary to distinguish evidence-based recommendations from misinformation and commercial claims. Cultural capital may therefore help determine how effectively health-related digital content is interpreted and incorporated into everyday life. The interaction between cultural resources and digital exposure is also compatible with research proposing models of health-oriented academic lifestyle in which social networks play an important moderating role (18). The present findings consequently suggest that health-oriented lifestyle is increasingly produced at the intersection of traditional cultural resources and new forms of digital socialization.

Socioeconomic status also showed a statistically significant positive effect on health-oriented lifestyle. Although its standardized direct effect was smaller than those of social media use, cultural capital, and social support, its significance confirms that material and structural resources continue to matter. Higher socioeconomic status can provide greater access to nutritious foods, private or organized exercise facilities, preventive healthcare, safe residential environments, transportation, health technologies, and leisure opportunities. Previous studies have similarly demonstrated that health-oriented lifestyle varies across socioeconomic and demographic groups (2, 9). International evidence further indicates that economic capital is associated with health behaviors but often operates in combination with social and cultural capital rather than independently (7). Thus, the relatively modest direct effect of socioeconomic status in the structural model does not imply that material conditions are unimportant; rather, it suggests that some of their influence may be embedded in wider networks of cultural, informational, and relational resources.

The significant effect of religiosity also deserves attention. Although its standardized coefficient was smaller than those of several other predictors, religiosity retained an independent positive association with health-oriented lifestyle. This result suggests that religious beliefs and practices may contribute to the regulation of everyday behavior through moral expectations, self-discipline, avoidance of harmful practices, and norms of responsibility toward the body and family. In Mashhad, where religious institutions and ritual practices form an important part of the social and cultural environment, this association is particularly plausible. Previous research has emphasized the importance of value and ritual dimensions in the organization of contemporary lifestyle and domestic life in Mashhad (15). The present findings indicate that religiosity remains relevant even when more contemporary influences such as social media and cultural capital are simultaneously considered. This suggests that women's health-oriented lifestyles may be formed through a hybrid combination of traditional normative structures and modern informational influences.

The results are also compatible with broader evidence showing that health-oriented lifestyle varies across social contexts, generations, and populations. Comparative research among mothers and daughters has demonstrated that the relative importance of social determinants can differ across generations (6). Research among young women in Shiraz has likewise shown that health-oriented lifestyle is associated with multiple social factors rather than a single determinant (5). Comparisons between Iranian and Afghan older adults have further demonstrated that health-related lifestyles differ according to sociocultural background (14). International research similarly indicates that healthy lifestyles vary considerably across cultural settings and population groups (3, 4). These findings reinforce the argument that health behavior should be

interpreted within its specific social context rather than treated as a universal expression of individual preference.

The findings also support a broader conceptualization of lifestyle as a socially constructed and context-dependent system of practices. Lifestyle is not merely a sum of discrete behaviors but a pattern through which social identities, values, resources, and relationships become embodied in everyday life. The changing spatial and residential organization of Mashhad has itself been associated with transformations in contemporary lifestyle (22). This indicates that health-oriented practices occur within changing urban environments and are influenced by access to spaces, services, institutions, and social relationships. Furthermore, lifestyle choices are frequently negotiated under conditions of competing expectations and demands. Research on lifestyle and conflict-resolution strategies has similarly emphasized the adaptive and negotiated character of lifestyle practices (23). The present results therefore suggest that health-oriented lifestyle among women in Mashhad reflects both structural opportunities and active adaptation to changing social conditions.

The overall explanatory power of the proposed model is particularly notable. The fact that the six variables explained 86.3% of the variance in the regression analysis and 88% in the structural model suggests that the selected determinants capture major dimensions of the social production of health-related behavior. These findings are consistent with prior reviews and meta-analytic evidence showing that health-oriented lifestyle is influenced by a complex constellation of social, cultural, psychological, and demographic factors (2). They also align with the broader conceptual literature cautioning against reducing lifestyle to isolated behaviors without considering its social and psychological organization (1). The structural model therefore provides empirical support for a multidimensional perspective in which economic position, cultural resources, social relationships, normative orientations, and digital environments operate simultaneously.

Taken together, the results point to a hybrid pattern of health-oriented lifestyle among women in Mashhad. Traditional relational resources such as social capital and social support remain important, while modern influences such as social media and cultural capital have become powerful determinants. Religiosity continues to provide a normative foundation, and socioeconomic status shapes the material conditions under which health choices become possible. This combination corresponds with international arguments that healthy living must be understood within cultural contexts rather than defined exclusively through biomedical or individualistic frameworks (4). It is also consistent with evidence showing that students and other social groups display different patterns of health-promoting behavior depending on their educational and social environments (21). Therefore, the health-oriented lifestyle of women in Mashhad can be understood as the outcome of an interaction between inherited social structures and contemporary cultural and technological transformations.

The present study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design does not permit definitive causal conclusions regarding the relationships between socioeconomic status, cultural capital, religiosity, social media use, social capital, social support, and health-oriented lifestyle. Second, all variables were assessed through self-report questionnaires, which may have introduced social desirability bias, recall bias, or common-method variance, particularly for socially valued behaviors such as healthy eating, exercise, religious practices, and preventive health behavior. Third, although stratified sampling was used to increase socioeconomic representation across residential areas of

Mashhad, the findings remain geographically specific and cannot automatically be generalized to women living in rural areas, smaller cities, or culturally different regions. Fourth, the study focused on six major explanatory variables, whereas other potentially important determinants, including health literacy, employment conditions, family structure, chronic stress, neighborhood characteristics, access to healthcare, psychological well-being, and digital health literacy, were not directly modeled. Finally, the high proportion of explained variance should be interpreted cautiously because relationships among conceptually related sociocultural variables and reliance on a common measurement format may have contributed to the strength of the observed associations.

Future studies are recommended to employ longitudinal designs in order to examine temporal ordering and determine whether changes in social capital, cultural resources, social media use, or social support produce subsequent changes in health-oriented lifestyle. Comparative studies across cities, provinces, rural and urban settings, and different age groups would help establish the generalizability of the model and identify context-specific determinants. Researchers could also test more complex structural models incorporating mediating and moderating mechanisms, particularly health information literacy, digital health literacy, perceived stress, self-efficacy, family support, and access to health services. The role of social media should be examined in greater detail by distinguishing active from passive use, health-related from entertainment-oriented use, platform type, exposure to professional versus nonprofessional content, and the credibility of information sources. Mixed-method and qualitative studies could complement quantitative models by exploring how women interpret health messages and negotiate competing traditional, familial, religious, and digital expectations in everyday life. Future research could also examine generational differences and test whether the relative importance of cultural capital, religiosity, and digital media changes across younger, middle-aged, and older women.

The findings have several practical implications for women's health promotion. Health policies and interventions should adopt a multidimensional approach rather than focusing exclusively on individual motivation or health education. Community-based programs should strengthen local social networks, collective participation, and supportive relationships because these resources can reinforce healthy behavioral patterns and sustain health-related changes over time. Digital health interventions should make greater strategic use of social media platforms while simultaneously improving media literacy and the ability to distinguish reliable health information from misleading or commercially motivated content. Educational and cultural programs should enhance women's health-related knowledge and interpretive competencies so that access to information can be translated into effective everyday practices. Particular attention should be given to women with fewer socioeconomic resources by improving equitable access to affordable physical activity, nutritious food, preventive health services, and trustworthy information. Health promotion programs in Mashhad should also be culturally sensitive and capable of integrating family, community, and religious resources with modern communication technologies, thereby developing interventions that are both socially acceptable and responsive to contemporary patterns of women's everyday life.

Acknowledgments

The authors express their deep gratitude to all participants who contributed to this study.

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.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

References

1. Brivio F, Viganò A, Paterna A, Palena N, Greco A. Narrative Review and Analysis of the Use of "Lifestyle" in Health Psychology. *International Journal of Environmental Research and Public Health*. 2023;20(5):4427. doi: 10.3390/ijerph20054427.
2. Vahedian M, Babaeifard A, Ganji M. Meta-Analysis of Studies on Factors Affecting Health-Oriented Lifestyle in Iran from 2006 to 2019. *Feyz Scientific Research Bimonthly*. 2021;25(2):891-900.
3. Marques A. Trends of Healthy Lifestyles among Adolescents: An analysis of More than Half a Million Participants from 32 Countries Between 2006 and 2014. *Frontiers in Pediatrics*. 2021;9:1-8.
4. Jayasinghe S, Byrne NM, Hills AP. The culture of healthy living: The international perspective. *Progress in Cardiovascular Diseases*. 2025;90:51-5.
5. Alborzi S, Movahed M, Mozaffari R, Enayat H. A Study of Health-Oriented Lifestyle among Young Women in Shiraz and Its Related Factors. *Biannual Journal of Population Policy Research*. 2021;7(1):319-44.
6. Golpayegani B, Maghsoudi S. Comparison of Social Factors Affecting the Health-Oriented Lifestyle of Mothers and Daughters in Sirjan. *Social Development*. 2024;18(1):103-30.
7. Mudd AL, Oude Groeniger J, Bal M, Verra SE, van Lenthe FJ, Kamphuis CBM. Testing conditionality with Bourdieu's capital theory: How economic, social, and embodied cultural capital are associated with diet and physical activity in the Netherlands. *SSM - Population Health*. 2023;22:101401.
8. Wang Y, Wen X, Liang W, Lin X. Capital endowment, health information literacy and healthy dietary behaviors: Evidence from a survey of Chinese rural residents. *Food Quality and Preference*. 2023;105:104766.
9. Zehni K, Rokhzadi MZ. Examining Health-Oriented Lifestyle and Its Relationship with Demographic Characteristics of Students at Kurdistan University of Medical Sciences. *Quarterly Journal of Nursing, Midwifery and Paramedical Sciences*. 2021;7(1):80-95.

10. Basiti S, Sharbatian MH, Shadloo N. The Relationship between Cultural Capital and Health-Oriented Lifestyle: A Study of Women Aged 20 to 48 in Damghan. *Welfare Planning and Social Development*. 2023;57(2):218-70.
11. Sharbatian MH, Talebi MA, Karamzadeh RN. The Role of Cultural Capital in Health-Oriented Lifestyle: A Study of Citizens Aged 20 to 49 in Damghan. *Contemporary Sociological Research*. 2023;12(22):133-64.
12. Tajbakhsh G, Ahmadi B. Sociocultural Factors Affecting the Health-Oriented Lifestyle of Youth. *Islamic Lifestyle with a Health Focus*. 2023;7(1):45-57.
13. Fereidouni Zarbi H, Darabi M, Pahlavan M. Urban Resilience in Coastal Cities of Mazandaran Province with Emphasis on the Role of Social Support and Health-Oriented Lifestyle. *Crisis Management*. 2024;13(2):69-84.
14. Nouri Kourabbaslou B, Matie Hagshenas N, Moeini SR. Comparison of Health-Oriented Lifestyle between Two Groups of Iranian and Afghan Older Adults: A Study of Older Adults in Qarchak. *Population Studies*. 2021;13(3):345-73.
15. Mahmoudi SA, Aghalatif A, Alipour R. The Position of Value and Ritual Dimensions among Factors Affecting Lifestyle and the Contemporary Home in Mashhad. *Greater Khorasan Research Journal*. 2021;12(44):39-56.
16. Golabi F. Media and Health-Oriented Lifestyle: A Study of Citizens' Health-Oriented Lifestyle in East Azerbaijan Province. *Iranian Social Development Studies*. 2022;14(54):65-80.
17. Mohammadpour E. Examining the Effect of the Type of Virtual Social Network Use on the Choice of a Health-Oriented Lifestyle. 9th International Conference on Interdisciplinary Studies in Humanities and Islamic Sciences of Iran; Tehran 2024.
18. Majidiparast M, Yazdi R, Momeni S. Developing a Health-Oriented Academic Lifestyle Model Based on Sports Motivation with the Moderating Role of Social Networks. *Bimonthly Journal of Education Strategies in Medical Sciences*. 2025;18(2).
19. Tajik N. Examining the Harmful Effects of Social Networks on Lifestyle and Beliefs and Strategies to Counter Them. *Strategic Research in Education*. 2025(44):269-89.
20. Razavizadeh SN, Iranmanesh H, Nouri A. The Role of Instagram in Identity Formation and Lifestyle: A Case Study of Male High School Students in Parand. *Communication Culture Studies*. 2025(102):187-211.
21. Chao DP. Health-promoting lifestyle and its predictors among health-related and non-health-related university students in Taiwan: a cross-sectional quantitative study. *BMC Public Health*. 2023;23:827. doi: 10.1186/s12889-023-15760-2.
22. Hendo M, Ivani H, Nourtaghani A. Examining the Impact of Changes in the Spatial System of Mashhad Houses on Contemporary Lifestyle. *Haft Hesar Environmental Studies*. 2021;9(36):35-58.
23. Alizadeh Manaman I, Ataei M. Conflict Resolution in Student Lifestyle: Scientific Strategies and Approaches. *Humanities and Islamic Sciences in the Third Millennium*. 2024;9(1):217-24.