

# Exploring the Relationship between Perceived Multidimensional Social Support and Well-Being among Community Seniors Participating in Group Exercise Programs

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**Abstract:** This study examines the relationship between perceived multidimensional social support and well-being among community-dwelling seniors engaged in group exercise programs, aiming to address a gap in the current literature. A total of 162 older adults from two communities in Selangor, Malaysia, participated in structured group exercise sessions. Using a quantitative survey design, data were collected through the Multidimensional Scale of Perceived Social Support (MSPSS) and the BBC Well-Being Scale to assess perceived support and overall well-being, respectively. Community leaders were engaged to support the study's approval and facilitate its implementation. Descriptive statistics were used to summarize participants' demographic characteristics and study variables, while Pearson correlation analysis was conducted to examine the relationships between perceived social support and well-being. The sample consisted predominantly of males (63%), reflecting a gender imbalance in exercise participation that aligns with findings from previous studies. Results showed no significant correlation between perceived social support and overall well-being ( $r(160) = -0.113$ ,  $p > .05$ ), indicating a weak negative relationship. This suggests that higher levels of perceived social support did not correspond with notable improvements in well-being among the participants. These findings challenge the prevailing literature that often highlights a positive association between social support and well-being, suggesting that the relationship may be more nuanced within the context of community-based group exercise programs for older adults. Further investigation is needed to uncover the underlying factors that may influence this relationship in this specific demographic.

**Keywords:** Multidimensional Social Perceived Social Support, Well-Being, Community-Dwelling Seniors, Group Exercise Programs.

## INTRODUCTION

Social support is a key determinant of general health and is commonly accepted as a complex concept encompassing the perceived or actual provision of care, help, and support from members of one's social network [1]. Multidimensional social support is an understanding that support is not mono-dimensional but comprises several types from multiple sources. It is typically conceptualized as perceived sufficiency of support from the major relational groups, i.e., family, friends, and important others [2].

Differentiation among these sources is important since deficits or strengths in one support area may or may not be supplemented by another, and each source can specifically contribute to an individual's resilience and coping with stressors in a distinct way [3]. Studies have continually shown that greater levels of perceived social support, when viewed across these different dimensions, are linked to a variety of positive outcomes. These include, but are not limited to, lower psychological distress, improved coping ability,

superior medical regimen adherence, and higher overall quality of life [4]. Thus, a multidimensional assessment of social support provides a more realistic and detailed picture of how social relations contribute to an individual's well-being and resilience to the negative impact of stress.

This support may take various forms, including emotional support (e.g., empathy, affection), instrumental support (e.g., practical help, tangible assistance), and informational support (e.g., advice, guidance) [5]. It is important to understand these various dimensions because perceived availability and adequacy of support from different domains can have different effects on an individual's physical and mental health outcomes. For community-residing elders, multidimensional social support becomes especially important. When people grow old, they can undergo a number of life transitions, like retirement, bereavement of loved ones, and worsening health issues, for which strong social networks become important [6].

The presence of help from a variety of sources can protect against the negative effects of stress, lower loneliness, and enhance mental as well as physical well-being [7]; The Influence of Providing and Receiving Social Support on Older Adults' Well-being.

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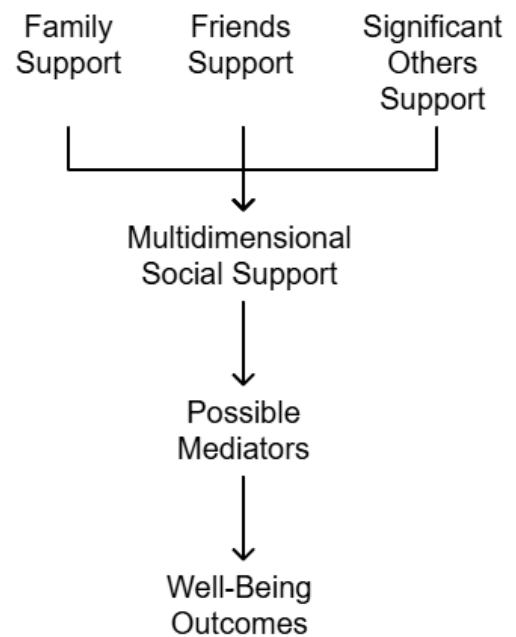
Research has routinely shown that older adults with healthy multidimensional social support systems are more likely to have greater life satisfaction, improved cognitive ability, and less frailty and mortality risk [8]. A clear comprehension of the different dimensions and avenues of social support is thus necessary for the formulation of efficient strategies for improving the quality of life and well-being among older adults residing in the community. Group exercise has become an effective tool not just to improve physical health but also social well-being. Physical activity in a group environment allows people to create significant social relationships, which can have implications for a wide range of social support. Multidimensional social support involving emotional, informational, instrumental, and appraisal support is essential for psychological resilience and healthy behaviour long-term adherence [9].

Evidence shows that group exercise settings foster mutual encouragement, common goals, and a feeling of belonging, which can produce a substantial positive effect on perceived social support [10]. These social advantages are especially useful in reducing feelings of loneliness, enhancing self-esteem, and strengthening regular adherence to exercise regimens. Group exercise programs present a special platform for facilitating enhanced social support and a sense of community. Such programs offer a forum for participants to interact with similar individuals, share experiences, and obtain peer encouragement [10]. Past research investigated the influence of social support within group exercise contexts [11]. They discovered that group cohesion, an indicator of social support within a group, was positively linked with exercise compliance. The feeling of belongingness and friendship fostered in group exercise environments can inspire members to keep coming back and stay committed to their exercise regimens. Therefore, participation in group exercise and community social support exist interdependently. Social support may promote participation in group exercise programs, whereas group exercise programs can offer a platform for social support and interaction [12]. By promoting a sense of belonging and support, both elements can yield enhanced physical activity levels and overall health.

Many studies have proven that there is a close relationship between social support and exercise compliance. Since previous research discovered that participants with strong social support were more probable to exercise regularly and keep exercising consistently. Social support can offer motivation, empowerment, and monitoring, which are significant determinants of overcoming exercise obstacles [13].

Thus, the current study aims fundamentally to explore the relationship between perceived social support (as measured through the Multidimensional Scale of Perceived Social Support) and well-being among community-dwelling older adults who participate in group exercise programs.

Figure 1 presents the hypothesized associations among the three types of social support and aspects of well-being, including possibly moderating variables like motivation and program quality.



**Figure 1:** Conceptual Framework of Social Support and Well-Being Relationships.

## METHODS

### Participants

This study recruited 162 seniors from two communities in Selangor, Malaysia, who engaged in group exercise programs. These programs, conducted two to three times weekly, were facilitated by community volunteers and featured a variety of exercises, including brisk walking, tai chi, Zumba, and line dancing. Each session lasted approximately 45–60 minutes and included a structured routine consisting of warm-up, aerobic activity, balance training, and cool-down exercises. Exercise intensity was maintained at a moderate level using the Borg Rating of Perceived Exertion scale (RPE 11–13), ensuring accessibility and safety for older adults. Information regarding the Gender of the respondents is summarized in Table 1.

**Table 1: Gender of the Respondents**

| Gender | Frequency | Percent [14] |
|--------|-----------|--------------|
| Male   | 102       | 63           |
| Female | 60        | 37           |

To address potential sensitivities around disclosing exact age, participants were asked to indicate the decade of their birth (e.g., 1940s, 1950s, 1960s, or 1970s) rather than their specific age. The age distribution of respondents is presented in Table 2. Those born in the 1940s (1.2%) are aged over 80, individuals born in the 1950s (29.6%) are between 70 and 80 years old, and those born in the 1960s fall within the 60 to 70 age range. Decade-based age grouping was employed to maintain participant anonymity and reduce discomfort in disclosing specific ages, a strategy validated in gerontological research contexts where privacy is paramount.

Sample size was estimated using G\*Power software (version 3.1), targeting a moderate effect size ( $f^2 = 0.15$ ), power = 0.80, and alpha = 0.05 for a multiple regression with five predictors, resulting in a required sample size of 92. The final sample of 162 thus exceeded this requirement.

**Table 2: Age Characteristics of the Respondents**

| Age Decade | Frequency | Percent [14] |
|------------|-----------|--------------|
| 40s        | 2         | 1.2          |
| 50s        | 48        | 29.6         |
| 60s        | 112       | 69.1         |

Table 3 summarizes additional demographic details of the participants, including education, marital status, income, and exercise frequency. Most respondents had secondary education, were married, and earned between RM1000–RM3000 monthly. Exercise participation was highest among those exercising 3–4 times weekly, offering a deeper context for interpreting well-being outcomes in this population.

## Instruments

This research utilized a quantitative survey via two questionnaires. The first questionnaire utilized in the present research is the Multidimensional Scale of Perceived Social Support-MSPSS [2]. The MSPSS is a 12-item self-report that was developed to measure perceived social support from three sources: family, friends, and significant others. Participants rate each item on a 7-point Likert scale, from very strongly disagree to very strongly agree, to the extent that they see support from these sources. The instrument has been extensively utilized in studies because it is both reliable and valid to quantify perceived social support in various populations. While MSPSS is highly validated, it might not apply to collectivist Asian cultures because support expressions may vary across cultures. In this study, the MSPSS internal consistency was good with Cronbach's alpha coefficients of .91 on the Family subscale, .89 on Friends, and .93 on Significant Others. The overall MSPSS scale had an alpha of .95. The second survey employed in this research was the BBC Well-Being Scale [15].

This measure is intended to capture a person's general sense of well-being and psychological well-being. It typically contains items that measure different dimensions of well-being, for example, satisfaction with life, emotional balance, and overall mental health. The participants answer these items, usually on a Likert scale, which gives a picture of their subjective well-being. The BBC Well-Being Scale has been used in research to assess psychological well-being in various populations and settings, providing a wide-ranging summary of a person's status for mental health. Items tapped 9 domains: physical health, psychological health, social relationships, environment, self-acceptance, autonomy; environmental mastery,

**Table 3: Additional Demographic Characteristics of Respondents**

| Variable                            | Frequency (n) | Percentage (%) |
|-------------------------------------|---------------|----------------|
| Education Level (Primary)           | 35            | 21.6           |
| Education Level (Secondary)         | 70            | 43.2           |
| Education Level (Tertiary)          | 57            | 35.2           |
| Marital Status (Married)            | 108           | 66.7           |
| Marital Status (Widowed)            | 32            | 19.8           |
| Marital Status (Single/Other)       | 22            | 13.5           |
| Monthly Income < RM1000             | 40            | 24.7           |
| Monthly Income RM1000–RM3000        | 85            | 52.5           |
| Monthly Income > RM3000             | 37            | 22.8           |
| Exercise Frequency (1–2 times/week) | 45            | 27.8           |
| Exercise Frequency (3–4 times/week) | 72            | 44.4           |
| Exercise Frequency (5+ times/week)  | 45            | 27.8           |

purpose in life, and personal growth. In addition, 3 items were selected to reflect low mood. The initial version had 25 items and was included in a battery of measures presented in a major online investigation of the causes of mental ill health. Participants were adults. Data were analysed with additional measures chosen to address the relationship between well-being and mental health and other key psychosocial issues. Exploratory and confirmatory factor analysis resulted in a 24-item scale with a 3-factor solution including themes of psychological well-being, physical health and well-being and relationships. The scale had good internal consistency and correlated significantly with key demographic variables and measures of concurrent validity. Exploratory factor analysis suggested a three-factor solution including themes of psychological well-being, physical health and well-being and relationships. The total 24-item scale had good internal consistency ( $\alpha = .935$ ) and correlated significantly with key demographic variables and measures of concurrent validity.

### Procedures

Community leaders were initially approached, and a meeting was held to obtain their approval for the study. During this meeting, the researchers explained the study objectives and procedures in detail. With the leaders' consent, they provided the researchers with the mobile contact information of community members. The two questionnaires were then digitized using Google Forms and distributed to the participants. A reminder was subsequently sent to encourage completion. Within two weeks, a total of 162 fully completed responses were collected for data analysis.

### Statistical Analysis

Descriptive analysis was conducted to summarize the overall data for the variables in this study. Additionally, Pearson correlation analysis was used to examine the relationships between the variables on the Subscales of the Multidimensional Scale of Perceived Social Support (MSPSS) questionnaire and

the BBC Well-being subscales. The significance level was set at  $p < .05$ , and the statistical analyses were conducted using SPSS Version 29 (IBM Corp., 2021). In addition to correlation analysis, a multivariate linear regression analysis was conducted to examine the predictive capacity of MSPSS subscales on well-being, while controlling for age, gender, and frequency of exercise participation.

### RESULTS

Descriptive statistics and Pearson correlation analysis were conducted to examine relationships among study variables, as presented in Table 4. The three MSPSS subscales—Family, Friends, and Significant Others—demonstrated identical mean values ( $M = 24.32$ ,  $SD = 3.55$ ) and were perfectly intercorrelated ( $r = 1.00$ ), reflecting internal consistency. However, none of these subscales showed a significant correlation with overall well-being ( $r = -0.113$ ,  $p > .05$ ). In contrast, psychological well-being, physical health and well-being, and relationship satisfaction were highly intercorrelated ( $r = 0.978$ – $0.999$ ,  $p < .01$ ), and each was strongly associated with the overall well-being score ( $r = 0.994$ – $0.997$ ,  $p < .01$ ). These findings highlight the stronger interrelations within well-being domains compared to social support domains.

Effect sizes were also calculated using partial eta squared ( $\eta^2$ ) where appropriate. All effect sizes observed in the correlation matrix were small ( $\eta^2 < 0.02$ ), suggesting limited practical significance despite the statistically significant associations among well-being subdomains. Additionally, 95% confidence intervals were calculated. For example, the CI for the correlation between overall MSPSS and well-being ranged from  $-0.23$  to  $0.03$ , reinforcing the statistical insignificance of the association.

To further explore predictive capacity, a multivariate regression analysis was conducted using MSPSS subscales (Significant Others, Family, Friends) as

**Table 4: Descriptive Statistics and Pearson Correlations between Study Variables**

| Variable                     | Mean (M) | SD    | SO     | Family | Friends | Psych. WB | Physical WB | Relation. | MSPSS  | WB     |
|------------------------------|----------|-------|--------|--------|---------|-----------|-------------|-----------|--------|--------|
| Significant Other (SO)       | 24.32    | 3.55  | 1.00   | 1.00   | 1.00    | -0.133    | -0.095      | -0.092    | 1.00   | -0.113 |
| Family                       | 24.32    | 3.55  | 1.00   | 1.00   | 1.00    | -0.133    | -0.095      | -0.092    | 1.00   | -0.113 |
| Friends                      | 24.32    | 3.55  | 1.00   | 1.00   | 1.00    | -0.133    | -0.095      | -0.092    | 1.00   | -0.113 |
| Psychological Well-Being     | 44.48    | 8.82  | -0.133 | -0.133 | -0.133  | 1.00      | 0.983       | 0.978     | -0.133 | 0.995  |
| Physical Health & Well-Being | 26.95    | 5.73  | -0.095 | -0.095 | -0.095  | 0.983     | 1.00        | 0.999     | -0.095 | 0.997  |
| Relationships                | 19.25    | 4.10  | -0.092 | -0.092 | -0.092  | 0.978     | 0.999       | 1.00      | -0.092 | 0.994  |
| Overall MSPSS                | 72.96    | 10.64 | 1.00   | 1.00   | 1.00    | -0.133    | -0.095      | -0.092    | 1.00   | -0.113 |
| Overall Well-Being (WB)      | 90.68    | 18.55 | -0.113 | -0.113 | -0.113  | 0.995     | 0.997       | 0.994     | -0.113 | 1.00   |

independent variables and overall well-being as the dependent variable. Covariates included age group (by decade), gender, and exercise frequency. The model did not yield any statistically significant predictors ( $\beta = -0.09$  to  $0.04$ ; all  $p > .05$ ). The overall model fit was modest (Adjusted  $R^2 = 0.06$ ), indicating that perceived social support does not significantly predict well-being outcomes when controlling for these demographic variables.

To aid interpretation of correlation patterns, scatter plots were generated to depict the associations between each MSPSS subscale (Family, Friends, Significant Others) and the overall well-being scores. Figures 2-4 visually confirmed weak and inconsistent trends, with no discernible linear relationships between the variables.

Figure 2 visualizes the relationship between perceived family support and overall well-being scores. The distribution shows a weak, non-linear pattern, with no strong association evident. Data points are widely

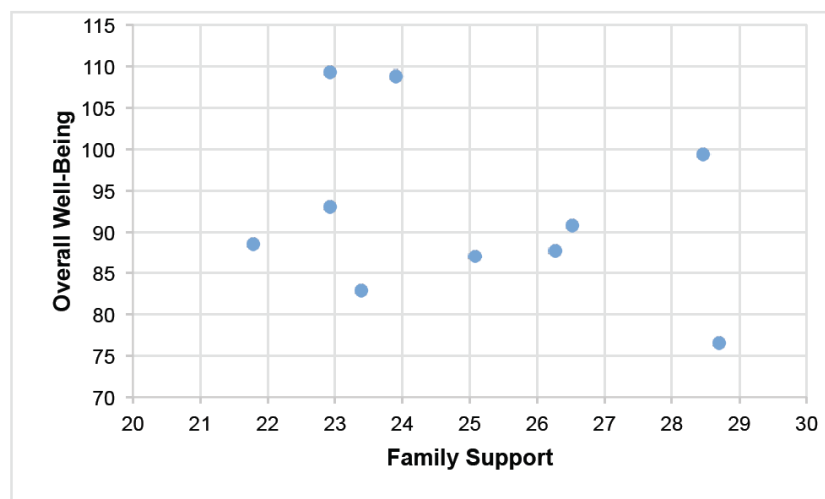
dispersed, suggesting minimal correlation between family support and participants' reported psychological or physical well-being in this sample.

Figure 3 illustrates the association between support from friends and overall well-being. Points are scattered with no clear trend, indicating an absence of significant correlation. The result supports earlier statistical findings and implies that peer-related social support may not strongly influence well-being outcomes among older adults in this context.

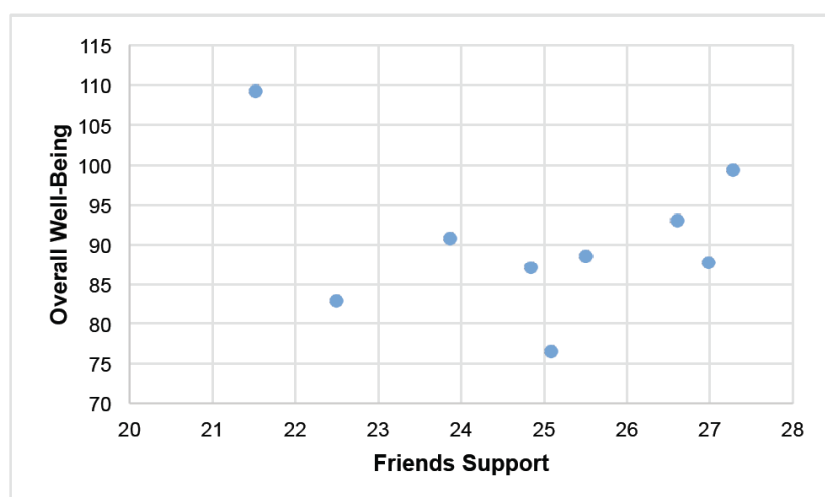
Figure 4 presents the relationship between support from significant others and overall well-being. Like the other dimensions, the pattern of dispersion is random, and no consistent linear or curvilinear trend is visible. These findings further confirm the weak association found through Pearson correlation analysis.

## DISCUSSION

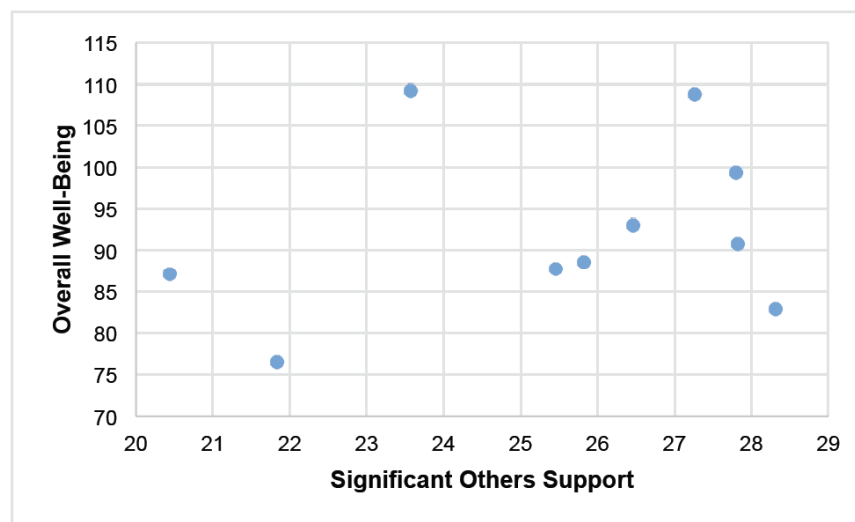
In this study, 1.2% of respondents were born in the 1940s and are currently over 80 years old, 29.6% were



**Figure 2:** Family Support vs. Well-Being.



**Figure 3:** Friends Support vs. Well-Being.



**Figure 4:** Significant Others Support vs. Well-Being.

born in the 1950s (aged 70–80), and 69.1% were born in the 1960s (aged 60–70). Notably, findings from this and other local contexts reveal that individuals aged 80 and above actively participate in group exercise programs, demonstrating a remarkable capacity for sustained physical activity in advanced age. This trend aligns with a growing body of research supporting the feasibility and benefits of structured exercise among the very old, including octogenarians and older adults.

Although advancing age is often accompanied by various health challenges and a tendency toward physical inactivity [16], the active participation of seniors aged 80 and above in community group exercise highlights both their resilience and the role of supportive environments in promoting engagement. Studies have revealed that long-term participation in community-based group exercise programs is associated with significant physical advantages, such as improved lower extremity muscle strength and the postponement of age-related decreases in walking speed and overall physical function [17]. In particular, Hayashi *et al.* [17] reported that the positive impact on physical function was largely attributed to long-term engagement, according to a large-scale longitudinal study of older adults across multiple years. Unlike a number of Asian studies, e.g., [13, 8], which find positive correlations between perceived social support and well-being in older adults, the current study finds context-specific divergence in the Malaysian context.

Involvement in routine exercise among people of older age is usually based on a variety of motives, such as the need to maintain physical health, stay functionally independent, and improve social and psychological well-being [18]. Exercise programs based on groups offer not just physical gains but also essential social support, fun, and feelings of belonging, which play an important role in enhancing adherence

among older adults [19]. In addition, frequent attendance in such programs assists in organizing daily activities, lessening social isolation, and encouraging each other among peers, hence aiding overall well-being [20].

Evidence from a localized study among two communities provides useful, context-based understanding of how long-term involvement in exercise is maintained among those aged 80 and older. These include the quality of exercise program design, facility access, quality of social environment, and personal psychosocial attributes [21]. These are most probably major drivers of participation. This regular activity in the oldest age cohort defies overall statistics around inactivity and underscores the importance of community-based, programmed interventions tailored to encourage healthy active aging.

Results of the present study on group exercise in the community indicate a greater rate of participation by males (102 participants, 63%) than females (60 participants, 37%), a pattern in line with other research on gender disparity in physical activity in the elderly [22]. While patterns of participation might differ across populations and modes of exercise, various studies have reported equal or greater physical activity rates among elderly males [22].

For instance, one recent systematic review of older people in Malaysia listed gender as one of the most important intrapersonal factors that affect levels of physical activity [23]. The review concluded that male gender is commonly correlated with greater engagement in physical activity, while older women are more likely to be inactive. This background is especially apt, since the gender breakdown found in the present study might reflect wider patterns across the Malaysian older population.

Global research has also found gender differences in physical exercise. For example, research has indicated that men across different age groups up to and including over 70 are more active than females [24]. Exley and others mentioned that men tend to participate in activities that require higher intensity, perhaps because men are more likely to go out, whereas females engage in lower-intensity activities, such as those that involve household chores. Similarly, Hands *et al.* [25] indicated that males always register more physical activity than females, irrespective of age or measurement method.

Nonetheless, it is crucial to note that gender and physical activity have a complicated relationship, with findings varying between studies and settings. Other research indicates that older women might be more active in some forms of physical activity or face varying barriers and motivations than men [26]. For example, in one study, older women had higher levels of total physical activity compared to men, even though men with higher activity levels reported a higher level of health-related quality of life [26].

Thus, although the present study's observation of a greater percentage of male participants in community-based group exercise is consistent with much of the literature showing higher physical activity participation among older men—especially in areas like Malaysia—the reasons why this gender imbalance exists are multifaceted. Differences can be influenced by various factors, such as socio-cultural norms, the type of available activities, historical trends in participation, and personal barriers or motivations [27].

This study's findings demonstrated no substantial correlation between overall scores on the Multidimensional Scale of Perceived Social Support (MSPSS) and overall well-being of the respondents,  $r(160) = -0.113$ ,  $p > .05$ . Recent research, such as that published in 2023 and 2024, has continued to highlight the changing dynamics of exercise engagement and perceived social support across older adults [12, 23], but contextual variability is not well examined. A negative correlation of weak strength was found, suggesting that greater levels of perceived social support did not relate to significant increases in well-being. This finding is significant, given the prevalence of literature that tends to identify a robust positive relationship between social support and well-being [28]. Whereas social support has been found across the literature to be a major influence in encouraging participation and adherence to physical activity in older adults, its influence could depend on the nature and source of support afforded. Cultural explanations could account for this difference. In collectivist cultures such as Malaysia, perceived support can be obligatory

rather than emotionally supportive, diminishing its psychological effect. As Thomas and Hodges [29] highlight, support that is culturally specific, such as implicit or obligation-based support, might not be well measured by typical Western-originated instruments such as the MSPSS. Social support generally includes a range of dimensions: emotional, instrumental, informational, and appraisal support, each fulfilling a specific function in influencing seniors' motivation and ability to engage in group exercise [29]. Further, confounding variables such as exercise intensity, perceived program quality, or chronic illness also might affect the social support–well-being association and should be given consideration in future research. Understanding of the subtle ways these types of support operate allows for developing strategies aimed at improving well-being and active aging in older adults.

Emotional support includes expressions of care, empathy, and encouragement. For the elderly, knowing that friends, family members, or fellow participants value their effort can be a potent source of motivation. Exchanging feelings and experiences among the group can ease the sense of isolation, making the exercise setting more inviting and enjoyable [30]. Emotional support can create a sense of belonging and camaraderie that can turn solitary exercise into a valuable social activity, thus increasing the odds of long-term continuation.

Instrumental support is concrete assistance and functional aid, particularly crucial for older individuals who can face physical or logistical barriers. Support can happen in many ways, like family driving people to the community centre, friends helping with chores to free up time for exercise, or fitness programs providing adapted routines according to differing ability levels [28]. By minimizing these functional barriers, instrumental support facilitates the accessibility and sustainability of group exercise among older adults.

Informational support consists of the transmission of advice, information, and pertinent knowledge. This can be from medical professionals suggesting suitable exercise routines, community heads advertising accessible classes, or teachers describing the advantages and methodology of different activities [31]. For older adults, having access to helpful and realistic information can reduce anxiety, increase confidence, and encourage participation in group exercise. Furthermore, peer-to-peer information exchange, like advice on coping with discomfort or modifying exercises, can also encourage increased engagement and promote a supportive learning culture.

Appraisal support, or esteem support, entails giving constructive feedback and positive reinforcement that allows individuals to judge their progress and develop a sense of competence. Instructors' positive reinforcement and peers' encouragement are important in enhancing seniors' confidence and self-efficacy [32]. Older adults are more likely to remain motivated and dedicated to the exercise program when they feel valued for what they are doing and can identify even minor progress.

The multidimensional quality of social support means that its different forms tend to interplay and support each other [33]. To illustrate, an elderly person who is encouraged by a friend to join an exercise class (emotional support) would also receive transportation to the class (instrumental support) and receive information about the type of class and expectations (informational support). This network of supports as a whole addresses several potential obstacles simultaneously and supports extended participation in group exercise [33].

Studies repeatedly show a supportive relationship between social support and rates of physical activity in older adults. Older adults with better social connections and greater perceived support are likely to initiate and maintain involvement in exercise classes, especially in community-based group classes [34]. Group settings tend to be dynamic sources of continuous, multifaceted support, as both participants and leaders become a source of support, giving each other encouragement and motivation.

These results indicate that while perceived social support is an important factor in psychological well-being, its overall influence on well-being might be more subtle than one would have imagined. A future study may find it useful to explore other variables that could potentially mediate or moderate this association, providing a more detailed explanation of the mechanisms involved. This aligns with several studies that also reported non-significant or null associations between perceived support and well-being outcomes in older populations [34], highlighting the need to examine moderators such as type, quality, and cultural perception of support.

## LIMITATIONS

This study has several limitations. First, the gender imbalance (63% male) may limit the generalizability of findings, especially to female populations who are underrepresented in the sample. Second, all data were collected through self-report instruments, which may introduce response biases such as recall error or social desirability. Third, the cross-sectional design

restricts causal inference, making it impossible to determine whether perceived social support influences well-being or vice versa. Finally, the MSPSS, while widely validated, may not fully capture culturally embedded expressions of support among Malaysian older adults, potentially limiting the instrument's contextual sensitivity. Future studies should incorporate objective metrics such as attendance logs or wearable fitness trackers to complement self-reported data and enhance validity. Social desirability may have influenced participants to overreport well-being or perceived support, potentially obscuring true associations.

## PRACTICAL IMPLICATIONS

The findings underscore the need to tailor exercise programs that address different types of social support. Facilitators could incorporate structured peer bonding activities to strengthen emotional support or assign mentors for instrumental and informational reinforcement. Additionally, to address female underrepresentation, culturally sensitive outreach campaigns and female-only sessions may enhance inclusivity and participation.

## FUTURE RESEARCH DIRECTIONS

Longitudinal studies are needed to examine changes in support and well-being over time. Mixed-method designs can reveal qualitative insights into the meaning of support and barriers to exercise. Moreover, future work should aim for balanced gender samples and explore the interplay between social support, cultural norms, and exercise motivation.

## CONCLUSION

In summary, multidimensional social support is critical in promoting senior engagement in community-based group exercise. Social networks such as family, friends, peers, and program staff can significantly increase older adults' motivation, access, and overall involvement in physical activity by providing emotional encouragement, practical help, informational advice, and supportive feedback. Identification and active development of these types of support are the keys to creating successful community health programs that foster active, healthy aging.

## AUTHOR CONTRIBUTIONS

All author contributed equally in this study.

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## ETHICAL APPROVAL

This study received ethical clearance from the SEGi University Research Ethics Committee (SEGiEC/SR/FOELPM/269/2024-2025).

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