Association between Social Mobility and Quality-of-Life Index in Women of Rasht: A Population-Based Study in the Iranian Context

Asiyeh Namazi[1], Hassan Rafiey[1]* , Mirtaher Mousavi[2], Ameneh Setareh Forouzan[2], Gholamreza Ghaedamini Harouni[2]

Abstract

Background: Life course research has shown that socioeconomic conditions in childhood have a profound impact on adult health. However, little is known about the different health effects of social mobility. This study was conducted to answer whether the intergenerational social mobility of women in Rasht is related to their quality of life index.

Methods: This cross-sectional survey conducted in 2020–2021, in which the researcher created a social mobility questionnaire, was used to study the association between social mobility and the quality of life index of women aged 30-65 in Rasht. The current socioeconomic status of 784 married women in this city was compared to the previous socioeconomic status of their parents. Also, Ferrans and Power's quality of life index questionnaire was used. Data analysis was done using t-test and ANOVA.

Results: The mean (SD) score for the overall quality of life index was 21.60 (4.23) of 30. The majority of participants had immobility (350 of them or 44.6%). There was no statistically significant correlation between women's intergenerational mobility and their quality-of-life index ($P = 0.734$). Still, there was a statistically significant difference between the average score of the quality of life in the socioeconomic groups of the participants.

Conclusion: Findings show that the women in Rasht did not have opportunities to promote their status or could not take advantage of these possibilities. Although our results did not show evidence for the effects of social mobility on quality of life, some scholars' findings support the idea of the impact (negative or positive) of intergenerational upward mobility on well-being.

Keywords: Quality of life, Life Satisfaction, Social Mobility, Intergenerational social mobility, Iranian women

Introduction

The social determinants of health are the circumstances in which people are born, grow up, live, work, and age and the systems put in place to deal with illness. These circumstances are in turn, shaped by a broader range of forces: economic, social policy and political (1). Socioeconomic status is a fundamental reason for health inequality. Those occupying higher rungs on the socioeconomic ladder in society tend to experience lower rates of morbidity and mortality compared to those placed lower in the social hierarchy (2). There is more or less inequality in all societies, although the level and nature of that differ from country to country. The degree of tolerance for inequality can depend

Corresponding author: Dr Hassan Rafiey, ha.rafiey@uswr.ac.ir

1. Department of Social Welfare Management, School of Education Sciences and Social Welfare, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran
2. Social welfare Management Research Center, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran

↑What is "already known" in this topic:
It is hypothesized that those who improve their socioeconomic status (SES) or experience upward intergenerational social mobility are happier and more satisfied with their lives and that for those individuals with a lower childhood SES, upward mobility predicts better health outcomes than does stable or downward mobility. In contrast, adverse effects of low SES on quality of life have been demonstrated in several studies.

→What this article adds:
This article illustrates how the opportunities available in society and the extent to which facilities are available to change the social situation for the women of Rasht. Also, the findings show the type of relationship between women's social mobility and the quality-of-life index as life satisfaction.

on the prevailing views in a given society about the fairness of existing inequality (3).

There is a view that the unequal distribution of household income can predict subjective well-being, and in contrast, reducing income inequality will strengthen subjective welfare in people (4). In a just society, the poorer children of the intelligentsia and the hardworking should be able to reach the same level as the rich and intelligent children (5).

We live in a period of active world transformation, as a wide range of tools allow a person to access global scientific, social, and cultural achievements and to apply the knowledge and skills acquired to transform their environment (6). However, many people stay in their main social class all their life, but some of them climb from one class to another with a lot of effort or use an opportunity. In the meantime, some of them stand in a lower class than their main social class due to lack of effort or bad luck (7). With their emphasis on meritocratic values, Western societies promote the notion that people can achieve anything they want if they are talented enough and willing to work hard (8).

Since the structural inequality of society will not be known without the study of social mobility, so this topic has been considered from various aspects in the field of social and health sciences (9). So far, various definitions of social mobility have been proposed. In general, this concept is described as a change in the socioeconomic status of individuals over time to another level in the social hierarchy during their lifetime (10, 11), and intergenerational social mobility is considered as changes in children's socioeconomic status at adultness compared with their parents (12). The basis of Sorokin's theory of social mobility (1992) is the position that between the strata of society, there are certain holes, stairways or elevators that allow individuals to move up or down from one stratum to another (13). On the other hand, Nikolaev and Burns (2014) define social mobility in terms of education, income and social class (14).

Opportunities are socially categorized and can improve or worsen everyday work conditions. Some scholars declare that low socioeconomic status is associated with an increased risk of declining health (15). Persistent social inequalities in health and the existence of clear gradients in both mortality and morbidity have brought social mobility into the focus of researchers and policymakers, both as a potential source of inequality and as a strategy to reduce it (16). In addition to socioeconomic status attained in adulthood, socioeconomic background also has significant and independent effects on health later in life, reflecting the long arm of childhood circumstances (2).

There are various approaches to affecting mobility on quality of life (17). One theory holds that transitions between classes in the social hierarchy can be stressful experiences (16). Sorokin subtly noted this nuance that an individual who changes social position is subject to more diverse influences, as opposed to a person who has maintained the same social status throughout their life (18). Accordingly, social mobility has a dissociative effect on people. The idea behind this is that social mobility is a mentally and socially demanding and stressful experience because of the major behavioral and cultural adjustment it requires

(17). On the other hand, some experts believe that people who improve their socioeconomic status (SES) and access to material and social resources or experience social mobility between generations are happier and more satisfied with their lives (19, 20). They believe that upward social mobility can increase an individual's level of life satisfaction by increasing their level of resources, which can help them achieve a specific goal and contribute to better social comparison (21). Niedzwiedz (2012), has shown a positive relationship between current SEP and quality of life using the needs satisfaction approach and life satisfaction and mental well-being (22). Also, some of the research suggested that upward social mobility may lead to better health outcomes by creating a sense of personal control, increasing psychological well-being through overcoming life-course limitations, promoting healthy behaviors and lifestyles, and developing a health-enhancing sense of gratitude (2). Yet, little is known about these effects on adult women's quality of life.

Social mobility in women and its scope shows the degree of permeability of social strata and the unequal construction of a society. Today, gender equality policies tend to improve the quality of life (QOL) for everyone, not just for the direct beneficiaries of the policies (women) (23). From a health perspective, the assessment and measurement of quality-of-life outcomes are central to the planning and implementation of health care to meet women's health needs (24). To the best of our knowledge, in Iran, limited research has evaluated social mobility in women. For example, the results of a study conducted by Safiri et al. (2006) on women in Tehran showed that in the last generation of these women, there had been social mobility towards their mothers, but this mobility is close to each other in social categories, and the girls have walked a very short distance from this social ladder. In other words, only a very small number have experienced social mobility as a leap in social status from generation to generation (9). Also, there have been no population-based studies investigating the relationship between social mobility and quality of life in Iran. Since there is little information about the status of social mobility in women in the northern cities of Iran, especially in the metropolis of Rasht, in this study, we intend to examine what changes have been made in the socio-economic status of that women over the past years, and it answers the question of whether using these opportunities has had an impact on their life satisfaction.

Methods

This study was descriptive research aimed at examining intergenerational social mobility and the state of the Quality-of-life Index among Rasht women, which was conducted between February 2020 and May 2021. Participants came from married women aged 30-65 years. The reason for choosing people in this age range is as having reached a stage of occupational maturity, at which further major changes in their class position are relatively unlikely (25). Rasht City has five urban areas; Regions 1 and 2, in terms of development, had the more favorable situation, considered the most developed zones. Regions 3 and 4 are cate-

gorized as developing areas, and Zone 5 is the least developed area (26). The samples were made up of 800 participants, selected by the cluster sampling method, and we used a two-stage probability sampling method; The first stage was two areas randomly selected from each region. In the next step, the desired samples were selected in proportion to the population size. Certain blocks were selected by systematic random sampling in each area. Also, to get a sufficiently large sample size, we used a design effect of 2 due to the different conditions in the regions and the possibility of respondents not answering the questions. Also, received retrospective information about participants' and parents' social prestige of occupations throughout life, education level, family mean income and type of housing ownership. These interviews were carried out in one consecutive session (20 minutes) in a private and comfortable setting in their homes. All ethical principles guiding the conduct of medical research involving human subjects were observed as outlined in the Helsinki Declaration. This research was registered by the Ethics Committee of Tehran University of Social Welfare and Rehabilitation Sciences (Code: IR.USWR.REC.1398.200). Ethics clearance has been obtained on the basis of oral consent.

Married women who are apparently healthy and agreed to take part in the study and who could communicate verbally to answer questions were included. At least having lived in Rasht city for one year at the time of the survey. Women with chronic illness, a history of mental illness, taking certain medications, and those who had lost a head of household or a close family member for various reasons, including coronavirus disease the year-ago, were excluded from the study. Also, respondents who were not living with any of their parents when they were aged 14 or did not remember the socioeconomic status of their family, were not selected for the analysis.

Since no previous study measuring the quality of life index in the total population of Iranian women was conducted, the sample size was estimated using the Krejcie and Morgan table. According to this table, for a population greater than 100,000, the sample size should be 384. It must be calculated to determine the optimal size of each cluster and the number of design effects. In this study, the design efficiency was assumed to be 2. The sample size should be determined based on the relationship Ncs = Nsrs Deffcs. In this context, Nsrs is the calculated sample size for simple random samples, and Ncs is the actual sample size for cluster samples with a design effect equal to Deffcs. This means that the cluster sampling method requires twice the initial sample size. Therefore, the required total sample size is 768 individuals. A total of 800 respondents were included in this study. Respondents who did not answer the satisfaction or importance questions (n=16) were excluded. After applying these exclusion criteria, 784 respondents were analyzed in the present study.

Intergeneration social mobility

The measures used to define social mobility include income, occupation, education, and social status (27). Our key explanatory predictors are the social classes of origin. In order to define the socioeconomic status of participants and their parents, the social mobility questionnaire was used that contained education level and occupation, type and size of the apartment (house), position in work organization, and monthly household income for participants and their parents. Moreover, the type of occupation, the type of place the participant spent their childhood, the participant's current type of place, and the participant's monthly household income.

We compared the social class position of respondents and their parents by using the Job Prestige class scheme, which was validated by Naebi and Abdollahian (2004). Based on this research, we created eight classes from the converted occupational status scores (the lowest status jobs = 1, the highest status jobs =8) (28). For the origin class, we used the status of the parent (father or mother) with the highest status when the respondent was 14, and for the destination class, it was measured by the current occupational class position of the respondent. We also used the average family income and housing as suitable economic indicators.

Based on the monthly income status of the family, we classified the income level into five levels (from the lowest income level = 1 to the highest income level = 5). Also, we classified individuals' home ownership into three groups; 1-personal ownership, 2- rented house, and 3- Organizational House. A difference between the origin and destination variables was classified as upward or downward social mobility.

Quality of Life Index standardized tool

Quality of life varies across time, space, and culture (29). The QOL index was developed by Ferrans and Power (1984) to measure the quality of life based on life satisfaction. The scale measures both satisfaction and importance regarding various aspects of life. Each part (satisfaction and importance) of the scale consists of 33 items in the four main domains:

• Health and Functioning (13): Health, Health Care, Pain, Energy Level, Self-Care, Control of Life, Longevity, Sex Life, Family Responsibilities, Utility, Concern, and Future.

• Social and Economic (8): Friends, emotional support from people other than your family, neighborhood, home, work/unemployment, education, and financial needs.

• Psychological/Spiritual (7): Peace of mind, belief in God, achievement of personal goals, happiness in general, life satisfaction, personal appearance, and self in general.

• Family (5): Family health, children, family happiness, spouse, and emotional support.

The QLI (total of 66 items) was measured on a visual six-point rating scale: very dissatisfied/unimportant (1), moderately dissatisfied/unimportant (2), slightly dissatisfied/unimportant (3), slightly satisfied/important (4), moderately satisfied/important (5) and very satisfied/important (6). Five score sets were calculated from the four domains and the overall QLI (30). The possible ratings for each item ranged from 1 to 6. A total score, which reflects the overall quality of life, is calculated from all items. The total score is then calculated by adding the weighted values of each answer and then dividing by the total number of items answered. Up to this step, the possible variation is between -15 and +15. We add 15 to the obtained values to avoid the

final score having a negative number, causing the total score of the instrument to vary between 0 and 30. The highest values represent a better quality of life (31).

The convergent validity of the Ferrans and Powers QLI was supported by the strong correlation between the total QLI score and the four measures of life satisfaction (r = 0.61, 0.65, 0.75, 0.77, 0.80) supported. In addition, internal consistency reliability for the QLI (full scale) was supported by Cronbach's alphas (73 to 0.99) in 48 studies (32).

In the Rafieis study (2014), a forward-backward translation procedure was used to develop the version of the questionnaire. Internal consistency (0.934) for the overall score indicated that all domains met the minimum standard for reliability. Cranach's alpha ranged from 0.74 to 0.90, with the exception of the family subscale (= 0.58). Test repeatability showed good results for an overall score and for other areas except (r=0.89, ICC=0.887) (33).

Statistical Analysis

Data analysis was performed using SPSS software version 23.0. Descriptive statistics are presented as mean ± standard deviation (SD) to summarize demographic and socioeconomic characteristics. Intrageneration social mobility and status of the life quality index were differentiated according to the participants' general characteristics and analyzed using t-test and ANOVA. Pearson's correlation analysis determined correlations between the quality-of-life index and social mobility. A two-sided $P < 0.05$ was considered statistically significant.

Results

Out of 800 participants in this study, 16 questionnaires were excluded from the final analysis due to incomplete some information. Almost half of the samples were in the range of age 30-39 years (47.4%). The mean age (SD) was 42.01 (9.27) years; 60.3% had a university degree (Bachelor's degree and higher). 73.5% of subjects were birthed in urban, and only 8.8% had a household income of less than 20000000 RIAL (80 United States dollars) a month. Further demographic and socioeconomic characteristics are shown in Table 1.

The mean (SD) score for the overall index of quality of life was 21.60 (4.23) out of 30. The results show that the highest score was related to the family domain (23.46), and the lowest was related to the social/economic domain (20.99). The full QLI dimension results are presented in Table 2. Table 1 also shows the socio-demographic data of the participants and the mean values of the QLI

To assess the objective dimension's socio-economic status (SES) of participants and their parents, the total scores obtained from the questions related to sections' education level, average monthly family income, type of housing ownership, and job status of individuals were calculated. Finally, socioeconomic status was divided into five categories: very low, low, middle, upper and very upper class. The results of the socio-economic status of the studied women are shown in Table 3. The majority of the participants, 42.3% (N = 332) were high and very upper SES level and a low percentage of the women had a poor economic status (24%). While 53.8% (N = 422) of the parents were in middle SES level and 17.9% of them had upper level. In other words, there is an increase in the number of people who are ranked in upper or very upper socio-economic status compared to their parents (332 vs 140). Also, the majority of participants had immobility (44.6%). This means that they remained in the same socioeconomic state as their parents. 15.10 of women had downward social mobility.

Table 3 shows the matrix of the participant's SES in comparison with the status of their parents, or in other words, displays the social mobility of women. The numbers related to the diagonal part of the table indicate immobility in

Table 1. Socio-demographic characteristics and QLI score among women (N = 784)

variable	Level	Study population	QLI score	Test result
		N (%)	Mean (SD)	F or t (*P*-value)
Age (years)	30-39	372 (47.4)	21.77 (4.48)	0.918 (0.32)
	40-49	233 (29.7)	21.45 (3.99)	
	50-59	132 (16.8)	21.25 (4.17)	
	60≤	47 (6)	21.91 (3.53)	
Education	Non-formal education	0 (0)	0 (0)	2.541 (0.01)*
	Under diploma	48 (6.1)	20.54 (4.47)	
	Diploma and Associate Degree	263 (33.5)	22.02 (4.14)	
	Bachelor's degree and higher	473 (60.3)	21.47 (4.24)	
Residence of birth	Rural	208 (26.5)	21.81 (4.03)	0.83 (0.40)
	Urban	576 (73.5)	21.52 (4.30)	
Employment	Employed	528 (67.3)	21.65 (4.14)	-0.54 (0.58)
	housewife	256 (32.7)	21.48 (4.43)	
Type of employment	public	235 (44.5)	21.29 (4.05)	-1.43 (0.15)
	Private	293 (55.5)	21.94 (4.19)	
Head of household	Woman	66 (8.4)	21.40 (3.21)	-.38 (0.69)
	Man	718 (91.6)	21.61 (4.31)	
Monthly income (RIAL)	Low (Less than 20000000)	69 (8.8)	20.83 (4.94)	1.233 (0.26)
	Moderate (20000000- 50000000)	270 (34.4)	21.58 (4.35)	
	High (More than 50000000)	445 (56.8)	21.73 (4.03)	
Urban areas	Zone1	154 (19.6)	21.40 (4.16)	1.789 (0.12)
	Zone2	153 (19.5)	21.87 (4.04)	
	Zone3	158 (20.2)	21.89 (3.84)	
	Zone4	162 (20.70	21.92 (4.61)	
	Zone5	157 (20)	20.88 (4.41)	

P-Value<0.05 is significant

Table 2. Mean of Quality-of-life index and its domains in Rashtian women and Pearson correlation results with social mobility score (N = 784)

Overall Quality of life index and its domain	Mean (SD)	Min	Max	r (P value)	CI 95% Lower	CI 95% Upper
Health and functioning	21.28 (4.53)	7	30	-0.032 (0.368)	-.102	.038
Social and economic	20.99 (4.48)	4	30	0.089 (0.013) *	.019	.158
Psychological/spiritual	21.81 (5.51)	0	30	0.009 (0.809)	-.061	.079
Family	23.46 (4.95)	4	30	-0.060 (0.095)	-.129	.010
Overall score QLF	21.60 (4.23)	7	30	0.012 (0.734)	-.058	.082
Total Importance score	64.57(13.87)	-58	80	0.167 (0.001) *	.099	.235
Total Satisfaction score	36.93(23.40)	-42	80	0.016 (0.655)	-.054	.086

*P-Value<0.05 is significant

Table 3. Matrix of intergenerational social mobility of women in comparison with the SES status of parents

The participant's SES	Parent's SES classification 5 No (%)	4 No (%)	3 No (%)	2 No (%)	1 No (%)	Sum
5- Very Upper class	1 (50)	0 (0)	1 (50.0)	0 (0)	0 (0)	2
4- Upper class	8 (5.8)	90 (65.2)	34 (25.0)	6 (4.0)	0 (0)	138
3- Middle class	8 (1.9)	161 (38.2)	169 (40)	84 (19.9)	0 (0)	422
2- Lower class	2 (0.9)	62 (28.3)	58 (26.5)	90 (41.1)	7 (3.2)	219
1- Very Lower class	0 (0)	0 (0)	2 (66.7)	1 (33.3)	0 (0)	3
Sum	19	313	264	181	7	784

women, and the numbers above the diameter indicate upward mobility. 132 of the participants (16.8%) showed downward mobility and 350 of them (44.6) were fixed in relation to the socio-economic status of their parents and there had been no change in their status. According to the results of the Analysis of variance, it was found that there was a statistically significant difference between the average score of the quality of life in the socio-economic groups of the participants (F = 6.028, P = 0.000). The results of the Pearson correlation test showed that there was a statistically significant and inverse correlation between the objective socio-economic status of parents and intergenerational social mobility in Rasht women (r = 0.185, P < 0.001).

Other results showed that there was no statistically significant correlation between women's intergenerational social mobility scores and their QLI (r = 0.012, P = 0.734). Also, among the dimensions of QLI, only its socio-economic domain showed a statistically significant and direct correlation with intergenerational social mobility in women (r = 0.089, P = 0.013) and total score of importance part (r = 0.167, P = 0.001) (Table 2).

Furthermore, one-way ANOVA test results showed that there was no statistically significant correlation between the quality of life and social mobility based on various areas of Rasht City ($P > 0.05$). However, the highest quality of life score was for participants who lived in developed areas.

Discussion

Intergenerational social mobility has enormous implications for individuals' well-being, attitudes, and behavior (34). In this study, we desired to examine the status of intergenerational social mobility in women and its relationship with their quality of life. The findings of our study show that the majority of women are in the same socioeconomic status as their parents, and their status has not changed while the majority of these parents were in a moderate situation. This shows that the women in Rasht had no opportunities to improve their status or at least could not take advantage of these opportunities.

Two comparable studies with data from this study reported that the intergeneration and intragenerational social mobility among women in the Tehran metropolis has a high ascending trend. The internal generational mobility is less observed in men, but intergenerational mobility was not different between men and women in this city. Their findings conclusively support the opportunity and the possibility of social mobility among women (9, 35).

Our findings showed that QoL was higher in families with upper-class SES. Similar findings were reported by Menati and et al. (2017) in Ilam (36). Socioeconomic status (SES) is one of the most important determinants of quality of life, while those with a lower SES have poorer health outcomes and have increased mortality and morbidity. As a result, they have a lower quality of life and are exposed to a greater number of health-related risk factors (37).

The present study showed that there was no significant relationship between participants' social mobility and their quality of life, but there was a statistically significant difference between the quality-of-life index in the socio-economic groups. Empirical studies usually find that individuals who consider themselves to be at the lower end of the socioeconomic hierarchy have worse health outcomes than individuals who consider themselves to be at the higher end of the socioeconomic hierarchy (38, 39). A survey evaluation finds that perceived social mobility is a significant predictor of self-reported physical health and psychological well-being. Also upward subjective mobility has a consistent and strong positive effect on health outcomes (40). In contrast, a classic claim holds that social mobility is a troublemaking and harmful experience (17). Friedman (2016) emphasizes that social mobility is a "painful situation" of social consequences and dual isolation from the two main classes and the destination class (41). Based on the findings of our study, the majority of participants did not experience social mobility and remained in the same status as their parents, so the real effect of mobility on their quality of life cannot be determined and there is a need for more studies in this regard. Unfortunately, since no study

has been conducted in our country with the aim of investigating the impact of social mobility on people's health and quality of life, we cannot compare the results of this study with other regions of the country. Therefore, it is suggested to conduct studies with the aim of evaluating the state of mobility in different regions of the country and its relationship with people's quality of life.

This study's major strength is the use of a dedicated instrument for measuring the quality-of-life index in the general population. This specific tool can show satisfaction and importance in life. In addition, social mobility is one of the social determinants of health, which has been neglected in our country's studies and is not a consideration to that. The most critical limitation of our study is its cross-sectional design, which limits causal inference. The second limitation of this study is that the data were collected using a self-reporting method, so there is a possibility of excessive or inadequate reporting.

Conclusion

To the best of our knowledge, this is the first study in Iran examining the social mobility status of women in Guilan Province and its relation to their quality of life. Also, in Iran, the quality of life index has never been evaluated as life satisfaction in the general population, and the studies conducted have examined the quality of life related to health. In recent years, the scientific community has become increasingly concerned about the health consequences of social decline. Many different social policies strive to promote equality and target different aspects of development or living conditions. The main goal is to provide equal access to the benefits of one society that benefit society as a whole. Social mobility as a social order, i.e., the surrounding world, requires the greatest possible flexibility from modern youth in relation to the changes taking place, as well as a sufficient degree of knowledge and professional skills. The decline in opportunities and mobility for current generations of Iranian women is probably the biggest negative impact of the ongoing boom in inequality. Interventional measures early in life can help restore opportunities in the country.

Conflict of Interests

The authors declare that they have no competing interests.

References

1. Chelak K, Chakole S. The Role of Social Determinants of Health in Promoting Health Equality: A Narrative Review. Cureus. 2023 Jan 5;15(1).
2. Gugushvili A, Bulczak G, Zelinska O, Koltai J. Socioeconomic position, social mobility, and health selection effects on allostatic load in the United States. PLoS One. 2021 Aug 4;16(8): e0254414.
3. Roex KLA, Huijts T, Sieben I. Attitudes towards income inequality: 'Winners' versus 'losers' of the perceived meritocracy. Acta Sociol. 2018 Jan 11;62(1):47–63.
4. Ngamaba K, Panagioti M, Armitage C. No TitleIncome inequality and subjective well-being: a systematic review and meta-analysis. Qual Life Res. 2018;27(3):577–96.
5. Krishna A, Agarwal S. Promoting Social Mobility in India: Modes of Action and Types of Support Organizations. J South Asian Dev. 2017 Oct 31;12(3):236–58.
6. Kalimullina O, Lukashova M. Social mobilityof modern students as a self-organizing process. In: InterConf, Challenges in science of nowadays. 2019. Washington, USA: EnDeavours Publisher, p. 116–22.
7. Ghafary Z, Haghighatian M. The Relationship between Objectified Cultural Capital and Intergenerational Social Mobility (A Case Study of Citizens of 30-54 Years of Age in the City of Gorgan, Iran). J Soc Sci Res. 2016;13(1):197–216.
8. Manstead ASR. The psychology of social class: How socioeconomic status impacts thought, feelings, and behaviour. Br J Soc Psychol. 2018 Apr 1;57(2):267–91.
9. Safiri K, Imani E. Inter-generation woman's social mobility in Tehran. Wom Dev Pol. 2006;4(1–2):141–58.
10. Kallunki J. Social and cultural mobility: rising to the middle class and cultural practices in contemporary Finland. Eur Sociol Rev. 2022 Oct 25; jcac049. Available from: https://doi.org/10.1093/esr/jcac049
11. Busemeyer MR, Guillaud E. Knowledge, skills or social mobility? Citizens' perceptions of the purpose of education. Soc Policy Adm. 2023 Mar 1;57(2):122–43. Available from: https://doi.org/10.1111/spol.12897
12. Álvarez–Rivadulla MJ, Camelo P, Vargas–Serani M, Viáfara D. The relational costs of crossing class lines. Br J Sociol. 2023 Mar 3;74(2):113–30.
13. Pidkurkova I. The problem of social selection in the system of higher education in the conditions of distance learning (through the prism of Pitrim Sorokin's theory of social mobility). J Youth Cent East Eur. 2020;7(11):11–29.
14. Chan TW. Social mobility and the well-being of individuals. Br J Sociol. 2018;69(1):183–206.
15. Hoven H, Siegrist J, Goldberg M, Ribet C, Zins M, Wahrendorf M. Intragenerational social mobility and depressive symptoms. Results from the French CONSTANCES cohort study. SSM - Popul Health. 2019 Jan 8; 7:100351.
16. Jonsson F, Sebastian MS, Hammarström A, Gustafsson PE. Intragenerational social mobility and functional somatic symptoms in a northern Swedish context: analyses of diagonal reference models. Int J Equity Health. 2017; 16:1.
17. Dhoore J, Daenekindt S, Roose H. Social Mobility and Life Satisfaction across European Countries: A Compositional Perspective on Dissociative Consequences of Social Mobility. Soc Indic Res. 2019;144(3):1257–72.
18. Jaime-Castillo AM, Marqués-Perales I. Social mobility and demand for redistribution in Europe: a comparative analysis. Br J Sociol. 2019 Jan 1;70(1):138–65.
19. Iveson MH, Deary IJ. Intergenerational social mobility and subjective wellbeing in later life. Soc Sci Med. 2017 Sep 1; 188:11–20.
20. Bridger E, Daly M. Intergenerational social mobility predicts midlife well-being: Prospective evidence from two large British cohorts. Soc Sci Med. 2020; 261:113217. Available from: https://www.sciencedirect.com/science/article/pii/S0277953620304366
21. Hsiao HHM, Wong K, Wan P san, Zheng V. The impact of experience and perceptions of social mobility on the life satisfaction of young people in Taiwan and Hong Kong. Asian J Comp Politics. 2019 May 14;5(4):319–36.
22. Niedzwiedz CL, Katikireddi S V, Pell JP, Mitchell R. Life course socio-economic position and quality of life in adulthood: a systematic review of life course models. BMC Public Health. 2012;12(628).
23. Audette AP, Lam S, O'Connor H, Radcliff B. (E) Quality of Life: A Cross-National Analysis of the Effect of Gender Equality on Life Satisfaction. J Happiness Stud. 2019;20(7):2173–88.
24. Kaplan RM, Hays RD. Health-Related Quality of Life Measurement in Public Health. Ann Rev Public Health. 2022 Apr 5;43(1):355–73.
25. Torche F. Gender differences in intergenerational mobility in Mexico. Centro de Estudios Espinosa Yglesias. 2015;(011):16.
26. Danesh A, Molaei N, Motamedimehr A. A comparative study of the

development of urban areas in Rasht by using multi criteria evaluation methods. Int J Hous Hum Settl Plan. 2016;11(34):1–16.

27. Leontopoulou S, Chletsos M. Intergenerational Social Mobility and Youth Well-Being in the Context of the Greek Socio-Economic Crisis. Soc Indic Res. 2023;165(1):333–53.

28. Crompton R. Class and Stratification. 1 ed. translated: Nayebi H, editors. Tehran: Ney.co; 2017. 235 p.

29. Muralidharan K. Introduction BT - Sustainable Development and Quality of Life: Through Lean, Green and Clean Concepts. In: Muralidharan K, editor. Singapore: Springer Singapore; 2021. p. 1–10.

30. Ferrans CE, Powers MJ. Ferrans and Powers Quality of Life Index: Questionnaires and Scoring. Chicago: University of Illinois. 2008. http://www.uic.edu/orgs/qli/questionaires/questionnairehome.htm

31. Kimura M, Silva JV da. Ferrans and Powers quality of life index. Rev Esc Enferm USP. 2009;43(SPE):1098–104.

32. Ferrans C. Development of a conceptual model of quality of life. Schol Inq Nurs Pract. 1996;10(3):293–304.

33. Rafiei N, Sharifian Sani M, Rafiey H, Behnampour N, Foroozesh K. Reliability and Validity of Persian Version of Quality-of-Life Index. J Maz Univ Med Sci. 2014;24(116):75–83.

34. Luo L. Heterogeneous Effects of Intergenerational Social Mobility: An Improved Method and New Evidence. Am Sociol Rev. 2021 Dec 3;87(1):143–73.

35. Ghadimi B. The comparison of Social Mobility Between men and women in Tehran metropolis. J Iran Soc Dev Stud. 2019;11(44):99–110.

36. Menati W, Baghbanian A, Asadi-Lari M, Moazen J, Menati R, Sohrabivafa M, et al. Health-related quality of life and socioeconomic status: inequalities among adults in West of Iran. Iran Red Crescent Med J. 2017;19(7): e55571.

37. McMaughan DJ, Oloruntoba O, Smith ML. Socioeconomic Status and Access to Healthcare: Interrelated Drivers for Healthy Aging Front Public Health. 2020; 8:231.

38. Demakakos P, Biddulph JP, de Oliveira C, Tsakos G, Marmot MG. Subjective social status and mortality: the English Longitudinal Study of Ageing. Eur J Epidemiol. 2018;33(8):729–39.

39. Richards L, Maharani A, Präg P. Subjective social status and allostatic load among older people in England: A longitudinal analysis. Soc Sci Med. 2023; 320:115749.

40. Gugushvili A, Zelinska O, Präg P, Bulczak G. Does perceived social mobility affect health? Evidence from a fixed effects approach. Soc Sci Med. 2022; 294:114705.

41. Friedman S. Habitus clivé and the emotional imprint of social mobility. Sociol Rev. 2016;64(1):129–47.