



The Relationship Between Family Emotional Support and Quality of Life in the Elderly

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Access this article online
Quick Response Code :



DOI: 10.22487/htj.v12i3.2115

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Page : 467-477

Article History:

Received: 2025-12-04

Revised: 2026-06-16

Accepted: 2026-07-31

Published by:

Tadulako University,
Managed by Faculty of
Medicine.

Website :

<https://jurnal.fk.untad.ac.id/index.php/htj/index>

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Abstract

Background: Quality of life among older adults is influenced by physical, psychological, social, and environmental conditions, with family emotional support potentially playing an important role. **Objective:** To determine the association between family emotional support and quality of life among older adults in the working area of Lembursitu Public Health Center. **Methods:** This quantitative correlational study used a cross sectional design involving 75 older adults selected through purposive sampling. Family emotional support was assessed using the Family Support Scale, while quality of life was measured using the WHOQOL-BREF. Because the 2×3 contingency table contained zero and sparse cells, the association was analyzed using the Fisher Freeman Halton exact test, with Cramer's V as the effect-size measure. **Results:** Poor emotional support was reported by 49 respondents and good support by 26. Quality of life was poor in 45 respondents, moderate in 4, and good in 26. A statistically significant and strong association was observed ($p < 0.001$; Cramer's $V = 1.00$). **Conclusions:** Family emotional support was strongly associated with quality of life among older adults. However, the cross-sectional design, nonprobability sampling, and unavailable covariate data limit causal interpretation and generalizability.

Keywords: family emotional support; quality of life; elderly; FSS; WHOQOL BREF

Introduction

The quality of life of older adults is influenced by interacting physical, psychological, social, and environmental conditions. Family support is one important component of this context and may include emotional, instrumental, informational, appraisal, and appreciation support¹. Emotional family support refers to affection, empathy, reassurance, listening, encouragement, and a sense of being valued by close family members². For older adults who face declining functional capacity, chronic symptoms, bereavement, or changes in social roles, these forms of emotional connection can provide a stable interpersonal resource. Social

support is also related to subjective well being because supportive exchanges may reduce feelings of isolation, strengthen coping, and maintain participation in meaningful daily activities³. Relationships with family and friends therefore remain relevant to life satisfaction during later life, although the quality and meaning of support may differ across individuals and family structures⁴.

Population aging makes the quality of life of older adults an increasingly important community health issue. Older people may experience physical limitations, chronic illness, cognitive changes, reduced income, loss of a spouse, and changing family roles, all of which

can influence how they evaluate their daily life. Previous Indonesian research has reported an association between family support and quality of life among older adults⁵. Evidence from other settings also shows that family support is not uniformly beneficial in every circumstance, because the adequacy, reciprocity, perceived burden, and personal expectations surrounding support can shape life satisfaction⁶. Quality of life should therefore be interpreted as a multidimensional outcome rather than a simple reflection of disease status. Research involving older carers similarly shows that personal health, care demands, social relationships, and environmental resources can interact in shaping perceived quality of life⁷. In Indonesia, cognitive and spiritual functioning have also been discussed as relevant dimensions of healthy aging, reinforcing the need to view elderly well being within a broad biopsychosocial context⁸.

The local relevance of family emotional support is particularly important in primary health care, where many older adults live with family members and receive day to day assistance outside formal services. Preliminary observations in the Lembursitu Public Health Center area indicated that some older adults required more emotional attention when coping with age related limitations. Research in health service populations has also shown that psychological resources can be associated with perceived quality of life⁹. At the same time, interventions that improve physical activity and participation can contribute to better quality of life in older adults, showing that emotional support is one part of a broader set of modifiable influences¹⁰. These findings support examining the emotional dimension specifically while avoiding the assumption that family support alone determines overall quality of life. The novelty of the present study is its focus on emotional family support within a defined community health center population in

Sukabumi City, where local family practices and service access may differ from those described in larger urban studies.

The main research question was: What is the association between family emotional support and quality of life among older adults in the working area of Lembursitu Public Health Center? The study hypothesized that a higher category of emotional family support would be associated with a better overall quality of life category. The objectives were to describe the recorded level of family emotional support, describe the overall quality of life categories, and analyze their association in the study sample. The objective was restricted to the overall quality of life outcome because the archived analytic results did not contain separate physical, psychological, social, and environmental domain scores. This clarification aligns the stated objective with the outcomes that are actually available for reporting.

The findings are expected to contribute to geriatric nursing and community health by identifying whether emotional support from family is associated with the way older adults evaluate their quality of life. Such evidence may help public health centers identify families that need education about respectful communication, regular contact, listening, and emotional reassurance. In routine community-based elderly care, assessment of perceived family emotional support may therefore complement broader evaluations of older adults' physical, psychological, social, and environmental well-being. Health professionals may also use these findings to encourage family involvement while recognizing that quality of life is multidimensional and cannot be attributed to emotional support alone. However, any practical implication must remain proportionate to the observational design. The present study does not test a family intervention and cannot establish that

increasing emotional support will by itself produce an improvement in quality of life. Instead, the results can be used as local evidence to guide assessment and to support future prospective or intervention studies that include relevant clinical, functional, and socioeconomic covariates.

Materials and Methods

Study Design

This study employed a quantitative descriptive correlational design with a cross sectional approach. The independent variable was the recorded category of family emotional support and the dependent variable was the recorded overall quality of life category. Both variables were measured during the same period, without follow up, so the design estimates association rather than temporal or causal effects¹¹. The study was conducted in the working area of Lembursitu Public Health Center in Sukabumi City. Data collection for the research was reported from October 2025 to January 2026. Because exposure and outcome were measured at one point in the study process, reverse direction of association cannot be excluded. For example, older adults with poorer health or poorer quality of life may require, perceive, or report family support differently from older adults with better functioning.

Sample

The accessible population consisted of 300 older adults recorded in the working area of Lembursitu Public Health Center, including 102 men and 198 women. The field study selected 75 respondents using purposive sampling. The original study documentation stated that the sample size was derived using the Slovin formula with a 10 percent margin of error¹². Because purposive sampling is a nonprobability method, this calculation should be understood as the operational basis used during recruitment rather than as a probability

based precision estimate for the association. A sensitivity calculation performed for the revised report indicates that, with $n = 75$, a two sided alpha of 0.05, and 80 percent power, an association corresponding to approximately Cramer's $V = 0.36$ or larger would be detectable under an approximate 2 by 3 Chi Square framework. This sensitivity calculation does not replace an a priori effect based sample size calculation. Inclusion criteria were age 60 years or older, attendance at the health center for a medical check, ability to communicate, and having family members. The exclusion criterion was unwillingness to participate. The archived manuscript did not contain the respondents' detailed age distribution, chronic disease profile, living arrangement, economic status, or functional status. These variables therefore could not be added to Table 1 without creating data that were not present in the study record, and their absence limits assessment of selection bias and residual confounding.

Data Collection Technique

Primary data were obtained directly from the 75 older adult respondents¹³. The manuscript source identified the measure of family emotional support as the Family Support Scale, abbreviated FSS, and this name is used consistently in the revised report. The available article archive did not retain the original source of the FSS, the number of items, response options, total scoring range, cut off used to distinguish poor from good emotional support, language adaptation procedure, or item level validity and reliability coefficients. These details cannot be reconstructed reliably from the summarized frequencies and are therefore not invented in this revision. The analysis retains the categories poor emotional support and good emotional support exactly as recorded in the source dataset, while the missing psychometric documentation is acknowledged as a major reproducibility limitation. For

interpretive clarity, the construct of emotional family support in this manuscript refers to perceived affection, empathy, attention, encouragement, reassurance, and willingness of family members to listen or remain emotionally available. These dimensions are conceptually distinct from instrumental assistance, financial help, health information, and appraisal support, although in daily family life the dimensions may overlap. Because the original item wording was not preserved in the supplied article file, the present report does not claim that every aspect of this conceptual definition was represented by a particular FSS item. Future replication should provide the complete instrument source, item map, response format, scoring direction, missing data rule, total score range, prespecified category thresholds, and psychometric coefficients obtained in a population comparable with the study sample. Reporting those details is especially important here because the observed contingency table shows complete category separation, making the validity of the categorization procedure central to interpretation. Quality of life was measured using WHOQOL BREF. The standard WHOQOL BREF contains 26 items and evaluates four domains, namely physical health, psychological health, social relationships, and environment¹⁴. Standard administration uses item responses on a five point scale, with raw domain scores transformed so that higher scores indicate better perceived quality of life¹⁵. The instrument is designed to capture a person's perception of life within cultural, value, goal, expectation, and environmental contexts rather than only the presence or absence of disease. Domain based reporting is generally more informative than a single global category because two older adults with the same overall perception may differ substantially in mobility, psychological distress, social relationships, or

environmental resources. However, the archived study materials did not identify the exact validated Indonesian version used, did not preserve the domain transformation worksheet, and did not document the evidence based thresholds used to create the reported poor, moderate, and good overall categories. The summarized dataset available for this revision also did not contain the four domain scores. Accordingly, this article reports the three observed categories as recorded and does not generate unobserved domain scores or new thresholds. This transparent approach preserves the original field data while clearly identifying the measurement information that should be documented in future replication.

Data Analysis Technique

Univariate analysis summarized respondent characteristics and the distributions of family emotional support and overall quality of life using frequencies and percentages¹⁶. The association between the two categorical variables was evaluated using the 2 by 3 contingency table shown in Table 2. The original manuscript reported a Pearson Chi Square test, but the observed table contains several zero cells and expected counts below five. Because those data do not satisfy the conventional Chi Square approximation assumptions, the revised analysis uses the Fisher Freeman Halton exact procedure for a 2 by 3 table. This procedure is an extension of Fisher's exact approach for contingency tables larger than 2 by 2 and is suitable when sparse frequencies make asymptotic approximation unreliable. The exact calculation conditions on the observed row and column totals and evaluates the probability of tables at least as unlikely as the observed configuration. For the corrected table with row totals of 49 and 26 and column totals of 45, 4, and 26, the two sided exact probability was approximately 9.89×10^{-21} and is therefore reported in journal format as p

< 0.001 rather than $p = 0.000$. Cramer's V was calculated as a descriptive effect size using the corresponding Pearson Chi Square statistic, sample size, and table dimensions. The corrected table produced a Pearson Chi Square statistic of 75.0 for descriptive effect size calculation and Cramer's $V = 1.00$. A value at this upper boundary reflects complete separation of the observed categories in this sample. It does not remove concerns about sampling, measurement, or residual confounding, and it should not be interpreted as a population causal parameter. The original Slovin based sample determination was not designed around an anticipated association. To provide additional transparency, a sensitivity calculation for $n = 75$, $\alpha = 0.05$, and 80 percent power under an approximate 2 by 3 Chi Square framework indicated that an association of about Cramer's $V = 0.36$ or larger would be detectable. This post study sensitivity calculation is descriptive and does not substitute for an a priori effect based sample size calculation. Statistical significance was assessed at $\alpha = 0.05$. No adjusted regression model was performed because the summarized analytic dataset available for revision did not contain age distribution, chronic disease, living arrangement, economic status, functional status, or other prespecified covariates. The absence of those variables is considered explicitly when interpreting the strength and generalizability of the observed association.

Ethical Consideration

Ethical approval was obtained from the Ethics Committee of the Faculty of Health Sciences, Muhammadiyah University of Sukabumi, with approval number 086/KET/KE-FKES/I/2025. The revised manuscript does not add undocumented consent or confidentiality procedures because those details were not contained in the supplied study file.

Result

This study involved 75 older adult respondents from the working area of Lembursitu Public Health Center. Table 1 presents the characteristics that were available in the summarized study record, namely sex, family emotional support category, and overall quality of life category. Men accounted for 42 respondents, or 56.0 percent, and women for 33, or 44.0 percent. Poor emotional support was recorded in 49 respondents, or 65.3 percent, while good emotional support was recorded in 26 respondents, or 34.7 percent. Overall quality of life was categorized as poor in 45 respondents, or 60.0 percent, moderate in 4, or 5.3 percent, and good in 26, or 34.7 percent. Detailed age, health, living arrangement, economic, and functional status distributions were not present in the archived analytic summary and therefore are not reported.

Table 1. Distribution of Respondent Characteristics (n = 75)

Characteristics	n	%
Gender		
Male	42	56
Female	33	44
Family support		
Poor Emotional Support	49	65.3
Good Emotional Support	26	34.7
Quality of Life for the Elderly		
Poor Quality of Life	45	60
Moderate Quality of Life	4	5.3
Good Quality of Life	26	34.7

Source: SPSS Data Analysis

Table 1 shows that the sample contained slightly more men than women. Most respondents were categorized as receiving poor family emotional support, and most were categorized as having poor overall quality of life. The descriptive distribution alone does not establish that the support category caused the quality of life category. Rather, it provides the marginal frequencies that were subsequently

examined in the exact association analysis. The similarity between the number of respondents with good emotional support and the number

with good quality of life becomes more informative only after examining the joint distribution in Table 2.

Table 2. Relationship Between Family Emotional Support and Elderly Quality of Life (n = 75)

Family Emotional Support	Quality of Life for the Elderly						Total		P Value
	Poor		Moderate		Good				
	F	%	F	%	F	%	F	%	
Poor	45	60	4	5.3	0	0	49	65.3	p < 0.001
Good	0	0	0	0	26	34.7	26	34.7	
Total	45	60	4	5.3	26	34.7	75	100%	

Source: Reanalysis of the original contingency table using the Fisher Freeman Halton exact procedure.

Table 2 was corrected so that the good emotional support row totals 26 respondents, or 34.7 percent, rather than the previously printed total of 24 respondents, or 44.4 percent. Among the 49 respondents with poor emotional support, 45 had poor quality of life and 4 had moderate quality of life, while none had good quality of life. Expressed within that support category, 91.8 percent of respondents with poor emotional support had poor quality of life and 8.2 percent had moderate quality of life. Among the 26 respondents with good emotional support, all 26 had good quality of life, corresponding to 100 percent within that support category. Thus, the table shows complete separation of the observed categories. Because zero and sparse cells invalidate the conventional Pearson Chi Square approximation, the primary inferential result is the Fisher Freeman Halton exact test, which gave $p < 0.001$. The corresponding descriptive effect size was Cramer's $V = 1.00$. The exact test establishes that the observed distribution is highly unlikely under the null hypothesis of no association, given the fixed margins. It does not show how much quality of life would change if emotional support were changed, nor does it establish temporal sequence. The result is therefore described as a strong association rather than an effect. The pattern should also be interpreted in light of the categorical scoring

system. When two continuous or ordinal constructs are converted to a small number of categories, threshold choices can create stronger apparent separation than would be visible in the underlying scores. Because item level scores and category cut offs were not retained in the supplied analytic file, this possibility cannot be evaluated. Nonprobability sampling, possible measurement classification effects, and unmeasured covariates may also contribute to the observed pattern.

Discussion

The revised analysis confirms that the joint distribution of family emotional support and overall quality of life was highly nonrandom in this sample. The complete separation is statistically striking, but a result of this magnitude warrants cautious interpretation. Older adults and families do not experience emotional support in isolation from health status, functional ability, cognitive condition, living arrangement, caregiving demands, and socioeconomic resources. Research on family carers shows that supportive family processes may help coping, but the effectiveness and meaning of support depend on the needs and context of the person receiving care¹⁷. Studies in Indonesian elderly care settings similarly describe family support as an important part of daily care and emotional security¹⁸. These

perspectives are compatible with the present association, but they do not prove that emotional support alone explains the observed quality of life categories. Several pathways may plausibly connect emotional support with perceived quality of life. Regular attention and reassurance can reduce perceived loneliness, provide opportunities to discuss symptoms or worries, encourage adherence to daily routines, and strengthen a sense of belonging. Family members may also facilitate contact with health services, transportation, social participation, and problem solving even when the support being measured is primarily emotional. Conversely, persistent conflict, neglect, or lack of communication may increase stress and reinforce feelings of dependence. These mechanisms are plausible explanations, not tested mediators in the present study, because no measures of loneliness, depressive symptoms, family conflict, functional independence, or health service use were included in the supplied analytic summary.

The high proportion of respondents with poor emotional support may reflect broader family and social dynamics. Family members may have employment obligations, physical distance, limited caregiving knowledge, competing responsibilities, or their own health problems. Older adults may also differ in willingness to express emotional needs, expectations about intergenerational roles, and comfort with seeking assistance. Social support has been associated with loneliness among older people¹⁹, while community studies have reported links between family support and quality of life²⁰. Emotional support may be especially relevant because feelings of attention, reassurance, and belonging can affect how older adults perceive security and social participation. Evidence concerning emotional support from peers also suggests that interpersonal emotional resources can be related to quality of life among older adults²¹.

However, the current dataset does not identify who delivered the support, how often support was provided, whether the older adult lived with the supporting family member, or whether support was perceived as welcome and adequate. Family support can also be reciprocal. Some older adults continue to provide childcare, financial guidance, household assistance, or emotional support to younger relatives. Therefore, a simple poor or good category may not capture the direction, reciprocity, or quality of family exchanges. Future studies should consider measuring frequency and source of support, co residence, family relationship quality, loneliness, and perceived burden so that the emotional support construct can be interpreted more precisely.

Quality of life in later life is multidimensional. Physical limitations and chronic disease can restrict mobility and independence, while psychological distress and social isolation may reduce life satisfaction. Environmental conditions such as housing safety, transportation, access to services, and financial resources may further shape daily experience. Family support may buffer some of these burdens, but it cannot substitute for appropriate medical treatment, rehabilitation, social participation, or economic and environmental resources. Large observational studies have shown that family support, multidimensional health, and life satisfaction are interrelated²². Family relationships also change over the life course, and the balance between autonomy, dependence, reciprocity, and caregiving can influence both older adults and relatives²³. Indonesian HTJ evidence showing improved elderly quality of life following structured physical activity further illustrates that quality of life can respond to multiple health and psychosocial influences¹⁰. For that reason, the present finding should be interpreted as evidence of association within a specific community sample, not as a single

factor explanation for elderly quality of life. A stronger future design would report WHOQOL BREF domain scores alongside the overall score so that researchers could determine whether emotional support is most strongly related to psychological, social, physical, or environmental quality of life. Such domain analysis could also reveal situations in which emotional support is high but physical or environmental constraints continue to limit overall well being.

The measurement characteristics are another important consideration. The observed table places all respondents with good emotional support in the good quality of life category and no respondent with poor support in the good quality of life category. Such complete separation can represent a genuinely strong relationship, but it can also be accentuated when broad constructs are converted into categorical outcomes using undocumented cut points. The supplied article archive did not contain the detailed FSS scoring rule or the WHOQOL BREF category thresholds used in the original analysis. Consequently, reproducibility of the category derivation cannot be independently checked from the current materials. Previous community research has nevertheless reported a relationship between emotional family support and quality of life in older adult or post stroke populations²⁴. The revised report therefore preserves the original categories while clearly separating empirical results from assumptions about measurement. This distinction is important because an exact p value can be statistically correct for the observed table even when uncertainty remains about how the categories were generated. Future studies should retain item level data, prespecify validated scoring rules, report domain level WHOQOL BREF scores, and present content validity and reliability evidence for the support instrument in the study

population. If a dichotomous support category is retained, investigators should justify the threshold clinically or psychometrically rather than choosing it after examining outcome data. Similarly, quality of life categories should be based on a validated or explicitly justified rule, and sensitivity analyses using continuous or domain scores should be considered when the instrument permits them.

The study also has sampling, design, and confounding limitations. Purposive recruitment from older adults who attended or were accessible through one public health center may overrepresent individuals who are connected to services and able to communicate. Detailed age distribution, chronic diseases, living arrangement, economic status, and functional status were unavailable in the summarized dataset, preventing an adjusted analysis. Residual confounding therefore remains a plausible explanation for part of the observed association. The cross sectional design also prevents determination of direction. Poor quality of life might alter an older person's perception of family support, while health decline may simultaneously influence both family involvement and quality of life. Family caregiving can impose burden on relatives, demonstrating that the well being of older adults and caregivers is interdependent²⁵. Structured family support has shown practical value in chronic disease management in HTJ research²⁶, supporting the relevance of family engagement while not implying that the present observational association is an intervention effect. From a service perspective, the findings support routine attention to emotional and social context during elderly assessment. Health workers can ask whether older adults have someone who listens to them, offers reassurance, maintains regular contact, and helps them feel respected. Such assessment can identify social needs that may otherwise be missed, but referrals or family education should

remain individualized and should not replace evaluation of medical, mental health, functional, or economic problems. The present data do not demonstrate that a particular family program will improve quality of life. Future research should use probability based or clearly defined consecutive sampling where feasible, prospectively document instrument validity, collect key clinical and social covariates, and test whether family focused interventions produce measurable changes in quality of life over time. A longitudinal design would help establish temporal sequence, while an intervention study could assess whether changes in emotional support are followed by changes in WHOQOL BREF scores. Qualitative interviews could also clarify how older adults define helpful emotional support and whether the meaning of support differs by sex, living arrangement, health status, or family structure.

Conclusion

In this sample of 75 older adults from the working area of Lembursitu Public Health Center, family emotional support was strongly associated with overall quality of life. After correction of Table 2, all 26 respondents with good emotional support had good quality of life, while the 49 respondents with poor emotional support had poor or moderate quality of life. The Fisher Freeman Halton exact test showed $p < 0.001$ and the descriptive effect size was Cramer's $V = 1.00$. These results describe a very strong association but do not establish causality. Interpretation should consider the cross sectional design, purposive sampling, unavailable covariate data, and incomplete documentation of the scoring rules used to create the FSS and WHOQOL BREF categories. Family emotional support remains an important consideration for elderly care assessment, and future studies should evaluate this relationship using fully documented

instruments, broader respondent characteristics, and prospective or intervention designs.

Acknowledgment

We would like to express our sincere gratitude to all individuals and institutions who supported the completion of this research, especially the elderly participants in the working area of Lembursitu Public Health Center who willingly took part in this study. We also extend our appreciation to the healthcare staff at Lembursitu Public Health Center for their cooperation and assistance throughout the data collection process. Our deepest thanks are directed to our academic supervisors and colleagues for their continuous guidance, encouragement, and valuable insights. We hope that the findings of this study may contribute to improving family involvement, enhancing emotional support, and ultimately supporting better quality of life among the elderly in the community.

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Conflict of Interest Statement

The author(s) declare no commercial, financial, or personal conflicts of interest related to this research. All authors approved the final manuscript and consented to its publication in *Healthy Tadulako Journal*.

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