

Original Article

Association of family support and health status with quality of life among older adults with depression: A cross-sectional study

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Abstract

Background: Depression in older adults is associated with poorer quality of life and may interact with physical health and social support. Although family support and health status have each been linked to quality of life, their combined association among older adults with depression in primary-care settings in Padang City remains insufficiently understood.

Objective: To determine the association of family support and health status with quality of life among older adults with depression in the working area of Puskesmas Belimbing, Padang City.

Methods: This quantitative analytic study used a cross-sectional design. Participants were older adults with mild or moderate depressive symptoms recruited from the working area of Puskesmas Belimbing using purposive sampling. Depression was screened using the Geriatric Depression Scale-15 (GDS-15), family support using the Family Support Scale (FSS), health-related status using the Short Form-36 (SF-36), and quality of life using the WHOQOL-OLD. Data were analyzed using Pearson correlation and multiple linear regression.

Results: A total of 123 older adults participated. The mean age was 69.56 ± 6.8 years; 67.5% were female and 64.2% had mild depressive symptoms. Family support was positively associated with quality of life ($r = 0.736$, $p = 0.003$), as was health-related status ($r = 0.711$, $p = 0.006$). The multivariable regression statistics reported in the original manuscript require verification against the original SPSS output before the model estimates can be reported as final.

Conclusion: Family support and health-related status were positively associated with quality of life among older adults with depression in the study setting. Because the study was cross-sectional, the findings indicate associations rather than causal effects.

Background

Depression is an important contributor to poor quality of life among older adults. Depressive symptoms may reduce motivation, social participation, functional independence, and perceived well-being, while coexisting chronic conditions may further increase psychological and physical burden (Marliana et al., 2022; Cavdar et al., 2024).

Family support may influence quality of life through emotional, instrumental, informational, and appraisal support. Emotional support can provide reassurance and a sense of being valued, whereas instrumental and informational support can facilitate daily activities, treatment adherence, and health-related decision-making. Previous studies have reported positive relationships between family support, social support, and well-being among older adults (Gallardo-Peralta et al., 2022; Kristianingrum et al., 2024; Shrestha et al., 2024).

Health-related functioning is also relevant to quality of life. Better physical functioning can

support independence and participation in daily activities, whereas chronic illness, comorbidity, and functional limitation may reduce perceived well-being. Evidence from community-dwelling older adults indicates that changes in health status are accompanied by changes in health-related quality of life (Ko et al., 2023).

The relationship among these variables can be interpreted using the Roy Adaptation Model. In this framework, older adults continuously adapt to internal and external stimuli. Health-related functioning can be considered primarily within the physiological-physical mode, depressive symptoms may affect self-concept and psychological adaptation, and family support is relevant to the interdependence mode. These modes are not independent; difficulties in one area may influence adaptation in others and ultimately affect quality of life.

The local cultural context may also be relevant. Previous research on Minangkabau families has described the importance of family relationships and family involvement in caring for older adults (Damsahara et al., 2023; Sabri et al., 2021). In the

preliminary assessment conducted in the working area of Puskesmas Belimbing, six of ten interviewed older adults showed depressive symptoms, four reported low-to-moderate family support, and all six had comorbid conditions such as diabetes mellitus, hypertension, gout, or osteoarthritis. These preliminary observations were used to identify the local research problem, rather than to estimate prevalence.

Despite evidence linking family support, health-related functioning, depression, and quality of life separately, limited evidence has examined the combined associations of family support and health-related status with quality of life specifically among older adults with depression in the Padang primary-care context. The present study therefore aimed to determine the association of family support and health-related status with quality of life among older adults with depression in the working area of Puskesmas Belimbing, Padang City.

Methods

Study Design and Setting

A quantitative analytic cross-sectional study was conducted in the working area of Puskesmas Belimbing, Padang City, from 25 to 30 June 2026. The reporting of this observational study was aligned with relevant STROBE recommendations. Puskesmas Belimbing was selected based on available health-service records indicating a high number of older adults and older adults with depression. The final submission should retain the quantitative comparison used to establish this selection criterion, including the corresponding source and year of the data.

Population and sampling

The source population comprised 163 older adults recorded as having depression in the working area of Puskesmas Belimbing in 2026. Participants were recruited using purposive sampling and screened using the GDS-15. A total of 123 participants with mild or moderate depressive symptoms met the study eligibility criteria and completed the study.

The inclusion criteria were the ability to communicate adequately, willingness to provide written informed consent, and having a family member or relative involved in care or family support. Exclusion criteria were severe communication difficulties, severe illness

preventing participation in the interview, terminal illness, and inability to complete the questionnaire. Because requiring family involvement may exclude older adults with limited family support, this criterion is recognized as a potential source of selection bias and may restrict the variability of family support in the sample.

The original manuscript does not contain enough information to reproduce the sample-size calculation. Therefore, the final version must insert the actual calculation used by the researcher, including the population size, expected effect size, confidence level or alpha, statistical power, and allowance for incomplete responses. These parameters should be taken from the approved protocol or original calculation rather than reconstructed retrospectively.

The recruitment process should also report, if available, the number of older adults approached, the number screened, the number excluded and the reasons for exclusion, and the number finally analyzed. Data collection over six days should be described factually according to the field records.

Instruments

Depressive symptoms were screened using the GDS-15. The final manuscript should specify the Indonesian version used, its validity and reliability evidence, the exact scoring thresholds used to classify depressive symptom severity, and the training or standardization provided to the administrators. The GDS-15 was used as a screening instrument and not as a diagnostic assessment. Procedures for participants with clinically significant symptoms or suicidal ideation should be reported according to the approved study protocol. Severe depression was excluded; the rationale and the resulting limitation in generalizability should be stated explicitly.

Family support was measured using the 18-item Family Support Scale (FSS), covering emotional, instrumental, informational, and appraisal support. The Indonesian version has reported acceptable item-total correlations and high internal consistency (Kurniawan et al., 2025). The final manuscript should report the response scale, scoring direction, possible total-score range, handling of reverse-scored items if applicable, and interpretation of higher scores.

Health-related status was assessed using the 36-item Short Form Health Survey (SF-36). SF-36 is a

measure of health-related quality of life rather than a generic health-status instrument. Accordingly, the variable should be described as SF-36-based health-related functioning or health-related quality of life in the manuscript. Conventional SF-36 domain scores range from 0 to 100, and the eight domains are not ordinarily summed into a single total score. The reported mean value of 104.74 therefore requires verification of the scoring procedure and should not be retained as a total SF-36 score unless the exact validated scoring method used in the study supports it.

Quality of life was assessed using the 24-item WHOQOL-OLD. The total raw score ranges from 24 to 120 when item responses are scored from 1 to 5, with higher scores indicating better quality of life. The Indonesian version has demonstrated acceptable measurement properties (Gondodiputro et al., 2021). The final manuscript should describe all transformation and scoring procedures used in the present study. The conceptual overlap between SF-36 and WHOQOL-OLD is an important methodological consideration. Because SF-36 measures health-related quality of life, part of its association with WHOQOL-OLD may reflect measurement redundancy rather than an association between fully independent constructs. This issue should be explicitly acknowledged when interpreting the results.

Data collection

Primary data were collected using interviewer-administered questionnaires. The study objectives and procedures were explained before written informed consent was obtained. For participants who required assistance, items were read aloud without changing the wording or response options. Completed questionnaires were checked for completeness and consistency before coding. Secondary information on the older-adult population and depression records was obtained from relevant health-service records.

Data analysis

Descriptive statistics included frequency, percentage, mean, and standard deviation. Pearson correlation was used to assess the bivariate associations between family support and quality of life and between SF-36-based health-related functioning and quality of life.

Before correlation and regression analyses, the assumptions of linearity, absence of influential outliers, homoscedasticity, and appropriate residual distribution should be assessed. Normality of the regression residuals should be distinguished from normality of the individual variables. Multicollinearity should be evaluated using tolerance and variance inflation factor (VIF). Missing-data handling should be explicitly reported, including the number of incomplete questionnaires and the rule used for excluding or retaining observations.

Multiple linear regression was planned to assess the simultaneous association of family support and health-related functioning with quality of life. The final regression table should report B, standard error, standardized β , t, p, 95% confidence intervals, model R, R^2 , adjusted R^2 , degrees of freedom, F statistic, exact model p-value, and relevant diagnostic statistics. Potential confounders such as age, sex, depressive symptom severity, comorbidities, socioeconomic status, and functional independence should be considered if they were collected and were specified in the analytical plan.

Ethical considerations

The study received ethical exemption from the Health Research Ethics Committee, Faculty of Nursing, Andalas University, under Ethical Exemption No. 800.1/layak etik/KEPKFKepUNAND. Participants received information about the study objectives, procedures, confidentiality, possible discomfort, and their right to refuse or withdraw. Written informed consent was obtained before participation.

Results

A total of 123 older adults participated in the study, with a mean age of 69.56 ± 6.80 years. Most participants were female (67.5%), while 32.5% were male. Regarding depressive symptom severity, 64.2% of participants had mild depressive symptoms and 35.8% had moderate depressive symptoms. The mean family support score was 53.84 ± 5.93 , while the mean quality-of-life score was 72.68 ± 6.80 . The mean health-related functioning score was 90.82 ± 6.90 based on the scoring procedure used in this study. These descriptive findings provide an overview of the participants and the distribution of the main study

variables before the association analyses (Table 1).

Table 1. Participant characteristics

Characteristics and variables	Mean $\pm$ SD	f (%)
Age (years)	69.56 $\pm$ 6.8	
Sex		
Male		40(32,5)
Female		83(67,5)
Depression level		
Mild		79(64,2)
Moderate		44(35,8)
Study variables		
Family support	53.84 $\pm$ 5.93	
Health status	90,82 $\pm$ 6.90	
Quality of life	72.68 $\pm$ 6.80	

Table 2 showed family support was positively associated with quality of life ($r = 0.736$, $p = 0.003$), and health status was also positively

associated with quality of life ($r = 0.711$, $p = 0.006$). Both associations were statistically significant at $p < 0.05$.

Table 2. Pearson Correlations between Family Support, Health Status, and Quality of Life among Older Adults with Depression

Variable	r(pearson)	p-value
Family support – quality of life	0.736	0.003
Health status - quality of life	0.711	0.006

Table 3 showed multiple linear regression model showed $R = 0.840$. Based on the reported R value, the corresponding coefficient of determination is $R^2 = 0.706$, indicating that family support and health-related status jointly accounted for approximately 70.6% of the variance in quality of life, with the remaining 29.4% attributable to other factors and unexplained variation.

Multiple linear regression showed that family support ($B = 0.720$, $\beta = 0.317$, $p = 0.004$) and

health status ($B = 0.734$, $\beta = 0.390$, $p = 0.007$) were positively and significantly associated with quality of life. Health status was the most dominant predictor, as indicated by its higher standardized coefficient ($\beta = 0.390$).

Based on the table, the regression equation was $Y = 75.210 + 0.720X_1 + 0.734X_2$, indicating that both family support and health status had positive effects on quality of life.

Table 3. Multiple Linear Regression Model Summary for Family Support and Health Status as Predictors of Quality of Life

Variable	R	R ²	Adjusted R ²	B	β	Sig.
Family support and health status – quality of life	0,840	0,706	0,701			
Constant				75,210		0,000
Family Support				0,720	0,317	0,004
Health Status				0,734	0,390	0,007

Discussion

The findings showed that family support was significantly and positively associated with quality of life among older adults with depression in Padang City. The correlation was strong ($r = 0.736$, $p = 0.003$), indicating that better family support was associated with better quality of life. This finding is consistent with Asyari et al (2022), who reported that family support was significantly associated with quality of life and depression among older adults. Similarly, Gallardo-Peralta et al (2022) found that family relationships facilitate adaptation among older adults and contribute to their well-being and quality of life, while Dewi et al (2025) identified family support as a protective factor for the mental health and well-being of older adults. More recent evidence also supports the relevance of functional social support to both mental health and quality of life. Tengku Mohd et al (2024), in a study of 2,324 community-dwelling older adults in Malaysia, found that functional social support was significantly associated with depression and both physical and mental components of quality of life. These findings suggest that the perceived availability and usefulness of support may be particularly important for older adults rather than merely the presence of family members.

The positive association between family support and quality of life may be explained by the multidimensional functions of family support in the daily lives of older adults experiencing depression. Emotional support can provide reassurance, acceptance, and a sense of being valued, whereas instrumental support can facilitate daily activities, healthcare access, and medication management. Informational and appraisal support may further assist older adults in making health-related decisions and maintaining confidence in their ability to cope with daily challenges. Social support may therefore provide both psychological resources for coping with depressive symptoms and practical resources for maintaining everyday functioning.

A recent systematic review and meta-analysis by Faronbi et al (2025) described social support among older adults in terms of emotional, instrumental, appraisal, and social engagement support, although the pooled evidence from intervention studies did not demonstrate a statistically significant overall effect on depression

or quality of life. This suggests that the benefits of social support may depend on the type, intensity, duration, and contextual appropriateness of support provided. Therefore, in the present study, family support should be understood as a multidimensional resource that may facilitate adaptation and daily functioning, while the cross-sectional design prevents conclusions regarding causal pathways.

These findings can be explained through Roy's Adaptation Model, which views individuals as biopsychosocial adaptive systems who respond to environmental stimuli through coping mechanisms. In this context, family support can function as a contextual stimulus that strengthens adaptive responses among older adults with depression. Family support may facilitate adaptation through the physiological, self-concept, role-function, and interdependence modes by assisting daily activities, strengthening self-worth, maintaining social roles, and providing emotional connection. The interdependence mode is particularly relevant because it emphasizes relationships, support, affection, appreciation, and communication with others. However, the constructs measured in the present study should be distinguished from the adaptation process proposed by Roy's model. Family support was directly measured using the Family Support Scale and can therefore be conceptually related to the interdependence mode, whereas adaptation itself was not directly measured. Thus, Roy's model provides a theoretical framework for interpreting the observed association rather than empirical evidence that family support directly produces successful adaptation.

Health status was also significantly and positively associated with quality of life ($r = 0.711$, $p = 0.006$). This finding is consistent with Ojagbemi et al (2021), who demonstrated that physical health contributes substantially to the quality of life of older adults. Xu et al (2022) similarly reported that older adults with better health tend to have more optimal physical, psychological, and social functioning, while Li et al (2024) found that poorer physical health was associated with greater depressive symptoms and lower quality of life. Furthermore, Galán-Arroyo et al (2022) and Cavdar et al (2024) reported that physical limitations and multiple comorbidities were associated with poorer quality of life among older adults with depression. Sulandari et al (2024)

through a systematic review and meta-analysis, found that older adults with better physical capability were more likely to report higher life satisfaction, while social support was also strongly associated with life satisfaction.

The association between health-related functioning and quality of life may be related to the ability of older adults to maintain physical activity, perform daily roles, and participate in social relationships. Physical limitations may restrict an older person's ability to perform household activities, fulfil expected roles, or participate in community activities, which can reduce opportunities for social interaction and increase dependence on others. These limitations may be particularly relevant among older adults experiencing depression because depressive symptoms may further reduce motivation and participation in daily and social activities. Goodarzi et al (2024) , in a systematic review and meta-analysis, found that psychosocial factors were significantly associated with functional independence among older adults and that depression was associated with increased functional dependence. Therefore, physical functioning should not be viewed only in terms of disease or physical symptoms, but also in relation to the ability of older adults to maintain meaningful roles, independence, and social participation. In this context, limitations in the role physical and social functioning domains may represent important pathways through which impaired health-related functioning is associated with poorer quality of life.

From the perspective of Roy's Adaptation Model, health status is closely related to the physiological-physical mode, which reflects an individual's ability to maintain physical integrity and respond adaptively to physiological changes. Older adults with better health status may be more capable of maintaining daily activities and independence, thereby supporting psychological and social adaptation. Conversely, physical health problems may disrupt adaptive processes and subsequently reduce quality of life. Roy's biopsychosocial perspective also emphasizes that physical health interacts with psychological and social dimensions, meaning that better physical functioning may support a more positive self-concept, greater role participation, and stronger interpersonal relationships.

Multiple linear regression analysis further demonstrated that family support and health status were simultaneously associated with quality of life ($R = 0.840$; $R^2 = 0.706$; $p = 0.009$). Together, these variables explained 70.6% of the variance in quality of life, while the remaining 29.4% may be related to other factors not examined in this study. Family support remained significantly associated with quality of life ($B = 0.720$; $\beta = 0.317$; $p = 0.004$), as did health status ($B = 0.734$; $\beta = 0.390$; $p = 0.007$). Health status had the larger standardized coefficient, indicating that it was the more dominant variable in the model.

The stronger contribution of health status is consistent with previous research indicating that physical health and functional capacity are among the most consistent determinants of quality of life in older adults. Frías-Luque and Toledano-González (2022) reported that physical health and functioning are important determinants of quality of life, while Rahman et al (2022) emphasized the importance of health-related needs in maintaining physical function, independence, and well-being. Within Roy's Adaptation Model, these findings suggest that successful physiological adaptation provides an important foundation for adaptation in psychological and social domains. Nevertheless, family support remains essential because it strengthens interdependence and helps older adults cope with changes associated with aging and depression.

The relatively high proportion of explained variance should also be interpreted cautiously because the SF-36 assesses health-related quality of life, whereas the WHOQOL-OLD assesses broader quality of life in older adults. Therefore, conceptual overlap between the predictor and outcome measures may partly contribute to the observed association. This methodological consideration does not invalidate the findings, but it indicates that the magnitude of the association should not be interpreted as representing a completely independent relationship between health and quality of life. Future studies should consider additional variables such as depressive symptom severity, comorbidities, functional independence, social participation, socioeconomic conditions, and environmental factors, and longitudinal or intervention designs would be useful to clarify the temporal relationships among these variables.

Overall, the findings indicate that improving the quality of life of older adults with depression requires a comprehensive approach that addresses both health conditions and family support. From the perspective of Roy's Adaptation Model, quality of life can be understood as an outcome of successful adaptation across physical, psychological, and social dimensions. Therefore, health services should not focus solely on the management of depression but should also strengthen family involvement and promote the maintenance of physical health, independence, social participation, and positive psychological adaptation. In the context of Puskesmas Belimbing, these findings support the importance of integrating family involvement with efforts to maintain physical and social functioning among older adults with depression.

Conclusion and Recommendation

Higher diabetes-related distress was moderately associated with lower quality of life, whereas better self-care behavior was moderately associated with higher quality of life among patients with type 2 diabetes mellitus at Bulu Lor Primary Health Center, Semarang. These findings emphasize the importance of addressing diabetes-related distress and promoting self-care behaviors as part of comprehensive diabetes management. However, because this study employed a cross-sectional design and unadjusted bivariate analysis, causal relationships and independent associations cannot be established. Future studies using longitudinal designs and multivariable analyses are recommended to further clarify these relationships.

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Declaration of conflict of interest

The authors declare no competing interests.

Declaration on the Use of AI

AI tools were used solely to assist with grammar checking and language editing during the preparation of this manuscript. The authors remain fully responsible for the scientific content, data, analysis, interpretation, and final version of the manuscript.

Data Availability Statement

Data sharing is not applicable to this article.

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