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Adaptation of The Family Health Scale In The Indonesian Context

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Abstract

Family health is extremely important because a family is the smallest community in which each member learns about healthy living. Therefore, a valid and reliable family health measurement tool that is cross-cultural is essential for understanding the state of family health worldwide. This study aims to adapt and test the psychometric properties of the Family Health Scale in the Indonesian context. The sampling technique used in this study was incidental sampling, distributed via social media, and completed by 1,843 participants. The validity test results using *Average Variance Extracted* (AVE) ranged from 0.289 to 0.628, while the Composite Reliability (CR) values ranged from 0.759 to 0.944. The results of the Confirmatory Factor Analysis showed that the Indonesian Family Health Scale model fit the data, with $\chi^2(319) = 1119$, $p < .001$; CFI = 0.972; TLI = 0.966; RMSEA = 0.0369 [90% CI: 0.0345; 0.0392]; SRMR = 0.0369; AIC = 112.974. The tested model shows that the four original dimensions of the instrument can be maintained, and that modifying the model through item reduction yields stronger statistical measures without altering the essence of the original dimensions. Based on these results, the Indonesian version of the Family Health Scale can be used as a family health measurement tool.

Keywords: Adaptation of measuring instruments, Family Health Scale, Indonesia, psychometric analysis

Abstrak

Kesehatan keluarga merupakan hal yang penting karena keluarga adalah komunitas terkecil tempat setiap anggota belajar tentang hidup sehat. Oleh karena itu, alat ukur kesehatan keluarga yang valid, reliabel, dan lintas budaya sangat penting untuk memahami kondisi kesehatan keluarga di berbagai wilayah. Studi ini bertujuan untuk mengadaptasi dan menguji sifat psikometrik Skala Kesehatan Keluarga dalam konteks masyarakat Indonesia. Teknik pengambilan sampel yang digunakan dalam penelitian ini adalah incidental sampling, didistribusikan melalui media sosial, dan diisi oleh 1.843 partisipan. Hasil uji validitas menggunakan Average Variance Extracted (AVE) berkisar antara 0,289 hingga 0,628, sedangkan nilai Composite Reliability (CR) berkisar antara 0,759 hingga 0,944. Hasil Confirmatory Factor Analysis menunjukkan bahwa model Skala Kesehatan Keluarga Indonesia sesuai dengan data, dengan $\chi^2(319) = 1119$, $p < .001$; CFI = 0,972; TLI = 0,966; RMSEA = 0,0369 [90% CI: 0,0345; [0,0392]; SRMR = 0,0369; AIC = 112,974. Model menunjukkan bahwa keempat dimensi asli instrumen dapat dipertahankan, dan modifikasi model melalui pengurangan item menghasilkan ukuran statistik yang lebih kuat tanpa mengubah esensi dimensi asli. Berdasarkan hasil ini, Skala Kesehatan Keluarga versi Indonesia dapat digunakan sebagai alat ukur kesehatan keluarga.

***Kata kunci**: Adaptasi instrumen pengukuran, analisis psikometrik, Indonesia, Skala Kesehatan Keluarga*

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1. Introduction

Family health is important because the family is the smallest community where each member learns about healthy living. Graham (1987) implicitly states that family health refers to the health of the father, mother, and children, as well as the interactions among these three parties. Macinko et al. (2005) state that a healthy family is a state of prosperity characterized by disease-free conditions and the optimal development of its members. Deffy and Sperry (2007) argue that family health is the optimal psychological, physical, and social condition for each member, as well as the interactions among members of the smallest group in society. Ennis and Bunting (2013) state that family health is the optimal physical and mental condition of all family members, from infants to the elderly. This view is similar to that of Caicedo (2014), who explains that family health is the optimal state of physical, mental, and cognitive functioning for every family member. Family health is the growth and interaction between cultural, social, mental, and physical aspects of each family member (Moral & Chimpén, 2021).

Unlike other experts' opinions, Silva et al. (2011) argue that family health is a state of social, mental, and physical well-being within the smallest unit of society and is not merely the sum of each member's condition. Silva et al.'s (2011) view is supported by Crandall et al.

(2020), who explicitly state that family health is a resource at the family unit level that grows due to the interconnection of health, social relationships, and the capacity of each family member, as well as the overall physical, social, emotional, economic, and medical resources of the family. Thus, it can be concluded that family health is not just the sum of the health of each family member but has a broader meaning because it encompasses the interaction of conditions among family members and across the overall family, including emotional, social, resource, and interactional conditions both within the family and outside the family.

Several studies have shown that families play a major role in the mental health of children and other family members. On the other hand, healthy family members allow the family to achieve its goals and aspirations more easily (Ai et al., 2022; Alcaide et al., 2023; Mugiraneza et al., 2024). The study by Farisni et al. (2022) also shows that family health awareness has a significant impact on stunting prevention. A healthy family also influences employee work commitment (Larasati et al., 2023) and contributes to a healthy society (Kuhlthau et al., 2022; Martínez-Montilla et al., 2017; and Laxer et al., 2020).

The development of family health measurement tools has already been carried out in several countries. Lanzarote-Fernández et al. (2019) adapted the family health behavior scale developed by Moreno et al. (2011) into Spanish. From 70 items, the scale was reduced to 27, comprising four factors: parental behavior, physical activity, mealtime, and child behavior. This scale was then further developed for Brazilians by Preto et al. (2022). Unlike the original version, the Brazilian version comprises seven factors: parental eating behavior, parents as role models for physical activity, daily eating behavior at the table, children's eating patterns, children's access to food, and children's physical activity.

The scales by Lanzarote-Fernández et al. (2019), Moreno et al. (2011), and Preto et al. (2022) share a common weakness: they measure family members' healthy behaviors rather than the family's health as a unit. The scale developed by Moreno et al. (2011) and adapted by Lanzarote-Fernández et al. (2019) and Preto et al. (2022) aims to measure the interactive behavior of parents and children to prevent obesity in children aged 5–12 years. This scale does not measure parental behavior with adolescents. Marvianto (2023) notes that in Indonesia, there is a survey called IFLS (Indonesian Family Life Survey). The IFLS provides data on demographic, socio-economic, educational, and public health conditions in Indonesia. This survey uses various measurement tools to assess different aspects of life, such as smoking behavior, quality of life, sleep disorders, depression, and so on. The survey uses several instruments to assess each family member's habits but does not measure family health as a whole.

The government's measurement tool for assessing family health in Indonesia is the Healthy Family Index (*Indeks Keluarga Sehat*/IKS). IKS has twelve indicators (Regulation of the Minister of Health of the Republic of Indonesia No. 39 of 2016 concerning Guidelines for Implementing the Healthy Indonesia Program with a Family Approach, 2016) including: 1) participation in the family planning program; 2) delivering babies in a healthy manner; 3) participating in vaccination programs for children under five; 4) implementing an exclusive breastfeeding program; 5) regular growth and development checks for children under five; 6) appropriate treatment for TB patients; 7) regular treatment for hypertension patients; 8) mental health care; 9) no family members smoke; 10) being a member of the National Health Insurance; 11) having access to clean water and clean health facilities; and 12) having a healthy toilet.

Several Indonesian studies on family health also use these twelve indicators. A literature review by Romdhonah et al. (2021) and empirical research by Saleha et al. (2023) show that the Healthy Family Index can be used to classify families as unhealthy, pre-healthy, or healthy. The Healthy Family Index can also be used to measure community conditions (Murnita & Prasetyowati, 2021). Despite the benefits of the Healthy Family Index, it also has drawbacks. Ako et al. (2024) reported that their study using the Healthy Family Index in North Luwu Regency, South Sulawesi, found that several items could not be used because they did not fit the participants' conditions. Research by Apriani et al. (2020) indicates differences between the indicators used in the Healthy Family Index and the factors of family health in daily life, such as community access to health services. Wulandari's (2021) study on the Healthy Family Index also found weaknesses in this measurement tool, as it does not capture public perceptions of the importance of family health. Wulandari's (2021) study focused solely on participants' behaviors, not on public knowledge and perceptions regarding family health.

Unlike the previously described scales, the family health scale developed by Crandall et al. (2020) aims to measure family health using several factors of family conditions. This scale consists of 32 items covering four factors: 1) emotional and social health processes; 2) family health lifestyle; 3) family health resources; and 4) social support from outside the family. The emotional and social health process factor includes each family member's emotional health and the family's social relationships. The family health lifestyle factor consists of healthy eating habits, physical activity, adherence to medical advice, and all family members helping each other develop healthy habits. The family health resources factor includes the availability of transportation, finances, and medical personnel to improve health. The fourth factor is social support from outside the family, including financial assistance, attention, advice, and shelter (Crandall et al., 2020).

Based on the validity and reliability tests conducted by Crandall et al. (2020) and Daines et al. (2021), this scale has demonstrated validity and reliability. It can also be used for research and clinical case assessment (Crandall & Barlow, 2022). The family health scale developed by Crandall et al. (2020) has also been translated into several languages, including Chinese (Wang et al., 2022) and Danish (Alawi et al., 2023). As far as the researchers know, there has not been an adaptation of this family health scale into Indonesian.

Based on the above explanation, there is a gap in measuring family health in Indonesia: no appropriate tool exists yet. On the other hand, the family health scale developed by Crandall et al. (2020) has been used across various family stages and in several countries but has not yet been validated in Indonesia. Therefore, this study aims to assess the psychometric properties of the Family Health Scale by Crandall et al. (2020) in its Indonesian version. According to Swan et al. (2023), measurement instrument research includes three domains: the domain, the item, and the response. This study examines whether the domains in this scale are represented by its items.

2. Method

This quantitative, cross-sectional study aims to adapt a measurement instrument. The measurement instrument adaptation in this study followed the scale adaptation stages outlined by Beaton et al. (2000), including: (1) translation, (2) forward-backward translation, (3) item selection, (4) item reduction, and (5) item selection. All five steps were carried out in this study. The translation from English to Indonesian and the back-translation into English were performed by two English-language experts. When participants were given the opportunity to ask questions, provide comments, or express complaints about the scale items, none were raised.

The participants in this study totaled 1,843 people aged 16 to 77 years, with a mean age of 32.35 years. Their family membership status was as father, mother, or children, covering various stages of family development (from from unmarried individuals, families without children, to those whose children have left home due to work or marriage). The sample was determined using incidental sampling techniques. Participants were recruited through social media and personal approaches.

Data were collected using Google Forms over three weeks. The measurement tool used in this study was the Family Health Scale (Crandall et al., 2020). This scale consists of 32 items grouped into four factors: emotional and social health processes, lifestyle, health resources, and social support from outside the family.

Participant responses were scored on a scale of 1 to 5. For favorable items, a score of 1 was given for the answer "Strongly disagree," 2 for "Disagree," 3 for "Unsure between agree and disagree," 4 for "Agree," and 5 for "Strongly agree." For unfavorable items, the scoring was reversed. The original items from Crandall et al. (2020) and the Indonesian version of the scale are available in Appendix 1.

After translation from English to Indonesian, the items on this scale were backtranslated into English. The translations from English to Indonesian and from Indonesian to English were carried out by two English-language experts working independently. After back-translation, some English words differed, but this did not affect the meaning of the sentences. There were two stages of psychometric validation in this study: internal consistency using the *Corrected Item-Total Correlation* and Cronbach's Alpha, and *Confirmatory Factor Analysis* (CFA) using the AMOS program.

3. Results

Before conducting psychometric validation, Kim (2013) and Mardia (as cited in Wulandari et al., 2021) stated that data must pass a normality test. The normality of the data distribution is assessed using skewness and kurtosis. For a normal distribution, skewness values should be between -2 and +2, and kurtosis values between -7 and +7 (Yusuf et al., 2024).

Appendix 2 shows that, in the descriptive statistics, the skewness values for each item ranged from -1.54 to +1.44, and the kurtosis values ranged from -1.11 to +3.94. These results indicate that each item on the Indonesian Family Health Scale is normally distributed. Based on these normality tests, internal consistency testing, and Confirmatory Factor Analysis (CFA), these analyses could be conducted.

Table 1. The distribution and examples of items of the Family Health Scale

No.	Subscale	Favorable Items	Unfavorable Items
1.	Family social and emotional health processes	2, 3, 4, 6, 7, 8, 9, 10, 11, 18, 19	1, 5
	Example of original item:	2. There is a feeling of togetherness	1. *We rarely express affection to each other.*
	Example of translation:	2. Ada perasaan kebersamaan	1. Kami jarang mengekspresikan kasih sayang satu sama lain.
2.	Family healthy lifestyle	12-17	-
	Example of original item:	14. *We help each other avoid unhealthy habits.*	
	Example of translation:	14. Kami saling membantu untuk menghindarikebiasaan tak sehat.	
3.	Family health resources	-	20-24, 29-32
	Example of original item:		23. *We do not trust doctors and other health professionals*
	Example of translation:		23. Kami tidak mempercayai dokter dan profesional kesehatan lainnya
4.	Family external social supports	25-28	-
	Example of original item:	26. *We have people outside of our family we can turn to when we have problems at school or work.*	
	Example of translation:	26. Kami memiliki orang-orang di luar keluarga kami yang dapat kami andalkan ketika kami memiliki masalah di sekolah atau tempat kerja.	

To assess the scale's internal consistency, we conducted item validity and factor reliability. Item validity was assessed using the corrected item-total correlation coefficient, and scale reliability was evaluated using Cronbach's Alpha. The results of the initial item validity and scale reliability tests are presented in Table 2. According to Cruchinho et al. (2024), a corrected item-total correlation coefficient is considered acceptable if it is above 0.30. Cronbach's Alpha coefficients between 0.70 and 0.80 are acceptable, 0.80 and 0.90 are considered good, and above 0.90 are considered excellent. Table 2 shows that all items of the Indonesian version of the Family Health Scale are valid and that the scale's four factors are reliable.

Confirmatory Factor Analysis (CFA) was performed using the original 32 items of the Family Health Scale across four factors (Model 1). However, the analysis indicated that Model 1 did not fully meet all specified criteria. CFA results for Model 1 were ($\chi^2(458) = 4478$, $p < .001$; CFI=0.871; TLI=0.861; RMSEA=0.069 [90% CI 0.067; 0.071]; SRMR=0.056; AIC=137.803). It can be concluded that the CFI and TLI values remain at the threshold for good fit (≥0.95), and that some factor loadings are low (0.304–0.845). Therefore, the researchers re-examined the potential for item redundancy by calculating *modification indices* and *residual covariances*. Several item pairs within the same factor showed high residual values; thus, these items were considered for gradual elimination. This was done to maintain the original number of factors rather than retaining items by reallocating them to other factors.

Table 2. Results of Initial Validity and Reliability Tests

Subscale	Corrected Item-Total Correlation	α
1. Family social and emotional health processes	0,63-0,82	0,95
2. Family healthy lifestyle	0,56-0,75	0,85
3. Family health resources	0,37-0,54	0,77
4. Family external social supports	0,68-0,72	0,85

In the second model, the researchers eliminated four items with low factor loadings, leaving 28 items. The four items removed were items 1, 5, 18, and 30. Model 2 produced ($\chi^2(319)=1119$, $p < .001$; CFI=0.972; TLI=0.966; RMSEA=0.0369 [90% CI 0.0345; 0.0392]; SRMR=0.0369; AIC=112.974). Compared with Model 1, Model 2 fits the data better overall. The CFI and TLI values indicated an improved fit, the RMSEA and SRMR values indicated a close fit, and the AIC value in Model 2 was lower than in Model 1. It can be concluded that Model 2 more accurately represents the construct.

Table 3 presents the factor loadings, validity, and reliability for Model 2. In general, most factors in the family health scale demonstrated good psychometric properties. Three out of four dimensions—family emotional and social health processes, family lifestyle, and social support from family—had CR values > 0.70, indicating adequate internal consistency. Additionally, AVE scores > 0.50 for those three dimensions also indicate strong validity as per the standards set by Hair et al. (2017). However, family health resources, has not yet been shown to be of good quality. Although the CR score was 0.759, the AVE score was 0.289, which is below the validity threshold (AVE < 0.50).

Table 3. CFA Results for Model 2 Tested in This Study (N=1843)

Factors	Items	Mean	SD	Factor Loadings	CR	AVE
Family social and emotional health processes	FHS2	4.12	0.825	0.786	0.944	0.628
	FHS3	4.31	0.766	0.771		
	FHS4	4.26	0.815	0.826		
	FHS6	4.15	0.801	0.811		
	FHS7	4.09	0.862	0.820		
	FHS8	3.79	0.993	0.767		
	FHS9	4.20	0.786	0.817		
	FHS10	4.17	0.867	0.833		
	FHS11	4.25	0.786	0.756		
	FHS19	4.22	0.770	0.732		
Family healthy lifestyle	FHS12	3.73	0.997	0.743	0.867	0.525
	FHS13	3.91	0.961	0.599		
	FHS14	3.86	0.928	0.754		
	FHS15	3.74	0.921	0.642		
	FHS16	3.91	0.944	0.727		
	FHS17	3.93	0.869	0.852		
Family health resources	FHS20	3.54	1.124	0.522	0.759	0.289
	FHS21	3.27	1.048	0.534		
	FHS22	3.33	1.081	0.720		
	FHS23	4.20	0.977	0.482		
	FHS24	3.57	1.080	0.637		
	FHS29	3.54	1.194	0.450		
	FHS31	3.77	1.075	0.472		
	FHS32	4.21	0.937	0.416		
Family external social supports	FHS25	3.71	1.008	0.797	0.838	0.565
	FHS26	3.62	1.009	0.796		
	FHS27	3.37	1.095	0.691		
	FHS28	3.52	1.045	0.716		

Note: CR (Composite Reliability); AVE (Average Variance Extracted)

4. Discussion

The results of the item validity and reliability tests (internal consistency) presented above demonstrate that the Indonesian Family Health Scale is strong in these areas. Additionally, the factor loadings for each item on this scale are high, and the average error is low.

The tested model shows that the four original dimensions of the instrument can be maintained: (1) family emotional and social health processes; (2) family lifestyle; (3) family health resources; and (4) social support from outside the family. The findings of this study indicate that model modification through

item reduction produces stronger statistical measurements without altering the essence of the original dimensions. The analysis shows that the number of items differs from the original scale, decreasing from 32 to 28. This change may indicate that certain indicators are not relevant to the Indonesian societal context.

For example, items 1, 5, and 18 are part of the family's emotional and social health. Regarding item 1 ("We rarely express affection for each other"), this does not represent Indonesian society. Affection among family members is not displayed as expressively as in the United States, where the original scale was developed. Subandi (2011) found that emotional expression in Javanese families tends to be less overt, resulting in less emotional warmth among family members than in Western countries. Love in Indonesian families is often expressed through functional behaviors, such as providing food and meeting financial needs. This differs from Western habits, where family members are taught to express emotions clearly or expressively (Kocur et al., 2025).

Furthermore, item 5 ("We rarely do things together") does not demonstrate sufficient discriminative power. This is likely related to the collectivist tendency in Indonesian society, which emphasizes engaging in activities together (Kocur et al., 2025). Moreover, many Indonesian families now have members with busy schedules of their own. As found in the study by Hutabarat et al. (2024), workers have come to appreciate the value of quality time, valuing brief but meaningful moments with family and friends.

The response to item 18, which was eliminated ("We remain hopeful even in difficult times"), likely lacked variation because Indonesia's collectivist culture leads individuals to feel they consistently receive support from others, even during tough times (Rani and Triarisanti, 2022). Belief in divine assistance is also very high in Indonesia, as most Indonesians still practice their faith (Hasyim and Nur, 2022).

In the final dimension, family health resources, item 30 ("Family worries and problems distract me when I am at work") was eliminated. This statement is quite different from the culture in Indonesia, where people tend to be confident in receiving support from others and from God, so worries and problems, no matter how great, do not interfere with work (Hasyim & Nur, 2022).

After these four items were eliminated, the Family Health Scale in the Indonesian context became more consistent with the theoretical framework used. A limitation of this adaptation is that most participants were from Java (Badan Pusat Statistik, 2023), which may have strongly influenced the CFA results. The results might differ if people from non-Javanese cultures had the opportunity to complete the same scale.

Most of the psychometric properties of the family health scale align well with the original scale. However, in the family health resources dimension, the AVE value remains below the recommended threshold. This dimension encompasses various family resources, so the researchers suspect it also includes indicators of other aspects. Nevertheless, all item indicators have good factor loadings, so the researchers decided to eliminate only one item and use the others to maintain conceptual equivalence with the original family health construct dimensions. Hair et al. (2022) emphasize that removing indicators can increase the AVE value but may risk reducing the content validity and conceptual coverage of the original instrument. Therefore, all indicators were retained based on statistical and theoretical considerations.

Research on the adaptation of the Family Health Scale has also been conducted in several other countries, such as Denmark for the long version (Alawi et al., 2023) and China for the short version (Wang et al., 2022). Unlike previous studies, which reported good instrument validation results in those contexts, this study still falls short of achieving the original scale's optimal psychometric properties. Although the overall reliability structure is good, some indicators needed to be eliminated, and the Family Health Resources dimension still shows relatively low convergent validity compared to the recommended cutoff. These differences indicate that cultural characteristics and social context can influence how research participants interpret indicators on this scale. Therefore, future researchers should ensure a thorough trial process with broader national representation.

Furthermore, this study provides opportunities to explore whether the structure of the translated instrument may be interpreted differently across demographic characteristics such as age, gender, marital status, education level, and occupation. The researchers assume that these factors also contribute to the development of a valid and reliable measurement tool that can be used across broader segments. Measurement invariance should also be

conducted to ensure that the family health construct measures the same thing across different respondent groups (Putnick & Bornstein, 2016).

5. Conclusion

The Family Health Scale by Crandall et al. (2020) has been adapted into Indonesian and adjusted for local conditions. This study aimed to assess the psychometric properties of the Indonesian version of the Family Health Scale. The Indonesian version of the Family Health Scale is robust and reliable. By eliminating items 1, 5, 18, and 30, this study demonstrates that the Indonesian Family Health Scale can be used to measure family health in Indonesia.

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Appendices

Appendix 1. Family Health Scale Indonesian Version

Instruksi:
Silakan Anda menjawab sejauh mana pernyataan berikut sesuai dengan keluarga Anda. Pilihlah jawaban:

1. Sangat tidak sesuai
2. Tidak sesuai
3. Ragu-ragu antara sesuai dan tidak sesuai
4. Sesuai
5. Sangat sesuai

Nilai Jawaban Partisipan:
Jawaban para partisipan dinilai dari 1 sampai 5.
Untuk item Favorabel: nilai 1 untuk jawaban “Sangat tidak sesuai”, nilai 2 untuk jawaban ” Tidak sesuai”, nilai 3 untuk jawaban “Ragu-ragu antara sesuai dan tidak sesuai”, nilai 4untuk jawaban “ Sesuai”, dan nilai 5 untuk jawaban Sangat sesuai”.
Untuk item Unfavorabel: Jawaban para partisipan dinilai dari 1 sampai 5. Nilai 1 untuk jawaban “Sangat sesuai”, nilai 2 untuk jawaban ”Sesuai”, nilai 3 untuk jawaban “Ragu-ragu antara sesuai dan tidak sesuai”, nilai 4untuk jawaban “Tidak Sesuai”, dan nilai 5 untuk jawaban “Sangat tidak sesuai”.

No.	English Version	Indonesian Version	Loading	Note
1	*We rarely express affection to each other.*	Kami jarang mengekspresikan kasih sayang satu sama lain.	0.59	Dropped
2	*There is a feeling of togetherness.*	Ada perasaan kebersamaan.	0.79	
3	*We care for one another.*	Kami peduli satu sama lain.	0.77	
4	*We support each other.*	Kami saling mendukung.	0.82	
5	*We rarely do things together.*	Kami jarang melakukan hal-hal bersama-sama.	0.57	Dropped
6	*The things we do for each other make us feel a part of the family*	Hal-hal yang kami lakukan untuk satu sama lain membuat kami merasa menjadi bagian dari keluarga	0.83	
7	*We have fun together.*	Kami bersenang-senang bersama.	0.77	
8	*We discuss problems and feel good about the solutions.*	Kami mendiskusikan masalah yang terjadi dan merasa puas dengan solusinya.	0.77	
9	*Family members pay attention to me.*	Anggota keluarga memperhatikan saya.	0.78	
10	*Overall, I am happy with my relationship with my family members*	Secara keseluruhan, saya senang dengan hubungan saya dengan anggota keluarga saya.	0.85	
11	*I feel safe in my family relationships.*	Saya merasa aman dalam hubungan dengan keluarga saya.	0.76	
12	*We make a point of being physically active during daily life.*	Kami memutuskan untuk aktif secara fisik dalam kehidupan sehari-hari.	0.68	

No.	English Version	Indonesian Version	Loading	Note
13	*We usually have fresh fruits and vegetables in our home.*	Kami biasanya memiliki buah-buahan dan sayuran segar di rumah.	0.61	
14	*We help each other avoid unhealthy habits.*	Kami saling membantu untuk menghindari kebiasaan tak sehat.	0.75	
15	*We make a point to follow medical recommendations.*	Kami memutuskan untuk mengikuti rekomendasi medis.	0.62	
16	*We help each other in seeking health care services when needed (such as making doctor's appointments).*	Kami saling membantu dalam mencari layanan kesehatan ketika diperlukan (seperti membuat janji bertemu dengan dokter).	0.72	
17	*We help each other make healthy changes.*	Kami saling membantu untuk membuat perubahan yang sehat.	0.82	
18	*We stay hopeful even in difficult times.*	Kami tetap berharap bahkan di masa-masa sulit.	0.64	Dropped
19	*We have beliefs that give us comfort.*	Kami memiliki keyakinan yang memberi kami kenyamanan.	0.77	
20	*If we needed help from others, we would have real difficulty finding transportation to get to that help.*	Jika kami membutuhkan bantuan dari orang lain, kami akan mendapatkan kesulitan dalam mencari transportasi untuk mendapatkan bantuan itu.	0.64	
21	*If we needed outside help, we would not know what sort of help was available.*	Jika kami membutuhkan bantuan dari luar, kami tidak akan tahu macam bantuan yang tersedia.	0.64	
22	*Financial difficulties would be an obstacle to getting outside help.*	Kesulitan keuangan akan menjadi hambatan untuk mendapatkan bantuan dari luar.	0.70	
23	*We do not trust doctors and other health professionals*	Kami tidak mempercayai dokter dan profesional kesehatan lainnya	0.39	
24	*A lack of health insurance would prevent us from asking for medical help (e.g., no health insurance or inadequate coverage).*	Kurangnya asuransi kesehatan akan mencegah kami untuk meminta bantuan medis (misalnya, tidak ada asuransi kesehatan atau cakupan tidak memadai).	0.59	
25	*We have people outside of our family who we can turn to for help (such as for advice, help with childcare, a ride somewhere, or to borrow some money or something valuable)*	Kami memiliki orang-orang di luar keluarga kami yang bisa kami minta bantuan (seperti saran, bantuan dalam mengasuh anak, tumpangan di suatu tempat, atau untuk meminjam sedikit uang atau sesuatu yang berharga)	0.76	
26	*We have people outside of our family we can turn to when we have problems at school or work.*	Kami memiliki orang-orang di luar keluarga kami yang dapat kami andalkan ketika kami memiliki masalah di sekolah atau tempat kerja.	0.75	
27	*If we needed financial help, we have people outside of our family we could turn to for a loan (e.g., for $200)*	Jika kami membutuhkan bantuan keuangan, kami memiliki orang-orang di luar keluarga kami, yang dapat kami andalkan untuk memberikan pinjaman (misalnya, untuk Rp 3.000.000,00)	0.77	
28	*If we needed help, we have people outside of our family who could provide our family with a place to live.*	Jika kami membutuhkan bantuan, kami memiliki orang-orang di luar keluarga kami yang dapat menyediakan tempat tinggal bagi keluarga kami.	0.77	
	In the past 30 days…	**Dalam 30 hari terakhir…**		
29	*My MENTAL health or the MENTAL health of my family members got in the way of MY FAMILY's normal daily activities (such as household chores, work, school, or recreation).*	Kesehatan MENTAL saya atau kesehatan MENTAL anggota keluarga saya menghalangi aktivitas sehari-hari yang normal dilakukan oleh KELUARGA SAYA (seperti pekerjaan rumah tangga, kerja, sekolah, atau rekreasi).	0.64	
30	*Family worries and problems distracted me when I was working.*	Kekhawatiran dan masalah keluarga mengalihkan perhatian saya ketika saya sedang bekerja.	0.58	Dropped
	In the past 12 months…	**Dalam 12 bulan terakhir…**		

No.	English Version	Indonesian Version	Loading	Note
31	*My family did not have enough money at the end of the month after bills were paid.*	Keluarga saya tidak memiliki cukup uang pada akhir bulan setelah tagihan dibayar.	0.61	
32	*My family did not have adequate housing.*	Keluarga saya tidak memiliki rumah yang memadai.	0.59	

Appendix 2. Table of Descriptive Statistical Test Results for Each Scale Item

No	Minimum	Maksimum	*Mean*	*SD*	*Skewness*	*Kurtosis*
1	1	5	2,57	1,17	0,31	-0,93
2	1	5	4,12	0,83	-1,25	2,34
3	1	5	4,31	0,77	-1,54	3,94
4	1	5	4,26	0,82	-1,48	3,14
5	1	5	2,59	1,14	0,48	-0,73
6	1	5	4,15	0,80	-1,25	2,67
7	1	5	4,09	0,86	-1,16	1,82
8	1	5	3,79	0,99	-0,84	0,41
9	1	5	4,20	0,79	-1,29	2,80
10	1	5	4,17	0,87	-1,34	2,32
11	1	5	4,25	0,79	-1,26	2,33
12	1	5	3,73	1,00	-0,70	0,02
13	1	5	3,91	0,96	-0,96	0,63
14	1	5	3,86	0,93	-0,89	0,69
15	1	5	3,74	0,92	-0,72	0,32
16	1	5	3,91	0,94	-1,07	1,09
17	1	5	3,93	0,87	-1,02	1,45
18	1	5	4,21	0,76	-1,31	3,27
19	1	5	4,22	0,77	-1,40	3,38
20	1	5	2,46	1,13	0,57	-0,54
21	1	5	2,73	1,05	0,13	-0,70
22	1	5	2,67	1,08	0,31	-0,66
23	1	5	1,80	0,98	1,44	1,76
24	1	5	2,43	1,08	0,53	-0,48
25	1	5	3,71	1,01	0,91	0,50
26	1	5	3,62	1,01	0,80	0,25
27	1	5	3,37	1,10	-0,51	-0,39
28	1	5	3,52	1,05	-0,70	-0,06
29	1	5	2,46	1,19	0,49	-0,80
30	1	5	2,99	1,21	-0,12	-1,11
31	1	5	2,23	1,08	0,72	-0,24
32	1	5	1,79	0,94	1,43	1,94

Appendix 3. Table of correlation between subscales

	1	2	3	4
1. Family social and emotional health processes	-	-	-	-
2. Family healthy lifestyle	0,84	-	-	-
3. Family health resources	0,65	0,55	-	-
4. Family external social supports	0,37	0,35	0,32	-