

Examining the Structural Model of Family Functioning and Quality of Life: The Mediating Roles of Family Flexibility and Family Strengths Among Nurses

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ABSTRACT

Nurses' quality of life is of particular importance because of the demanding nature of their profession, night shifts, and interpersonal pressures, as poor quality of life may adversely affect their own health and that of their patients, family relationships, and quality of working life. The present study aimed to examine the structural model of the relationship between family functioning and quality of life, with family flexibility and family strengths as mediators, among female nurses employed in public hospitals in Khoy County. This study employed a correlational design using structural equation modeling. The statistical population consisted of all female nurses working in public hospitals in Khoy County, from whom 210 nurses were randomly selected from four public hospitals. The research instruments included the World Health Organization Quality of Life Questionnaire (World Health Organization [WHO], 1996), the Family Assessment Device developed by Epstein et al. (1983), Shakeri's Family Flexibility Questionnaire (2003), and the Family Strengths Questionnaire developed by Sham et al. (2001). Data were analyzed using structural equation modeling in SPSS version 26 and AMOS version 24, together with the Preacher and Hayes bootstrap procedure. The results indicated that family functioning had significant direct effects on quality of life ($\beta = .430$), family flexibility ($\beta = .358$), and family strengths ($\beta = .282$). Family flexibility ($\beta = .301$) and family strengths ($\beta = .481$) also had significant direct effects on quality of life. Bootstrap analysis further demonstrated significant indirect effects of family functioning on quality of life through family flexibility ($\beta = .108$) and family strengths ($\beta = .134$), $p < .01$. Overall, family functioning was associated with quality of life among female nurses, while family flexibility and family strengths played mediating roles in this relationship. Accordingly, consideration of these family-related components may contribute to explaining the quality of life of nurses working in hospital settings.

Keywords: family flexibility, nurses, family strengths, family functioning, quality of life

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Introduction

Quality of life is a multidimensional construct that encompasses individuals' perceptions of their physical health, psychological well-being, social relationships, environmental conditions, and capacity to function effectively within the contexts in which they live and work. Contemporary approaches increasingly emphasize that quality of life cannot be understood solely through individual-level health indicators, because it is shaped by interactions among personal, familial, occupational, social, and structural determinants.

From a social determinants perspective, well-being is influenced by the conditions in which people are born, live, work, and age, as well as by the resources, relationships, and opportunities available within their immediate environments (1). Accordingly, quality of life has become an important outcome in health research and program evaluation because it reflects not only morbidity or functional status but also the broader lived experience of individuals across multiple domains (2). A social model of health similarly proposes that psychological and physical well-being are embedded within social systems and cannot be adequately explained without considering contextual resources and constraints (3). This multidimensional perspective is especially relevant to nurses, whose occupational demands intersect directly with their family responsibilities, social relationships, recovery opportunities, and psychological resources.

Nursing is widely recognized as a demanding occupation characterized by heavy workloads, rotating or night shifts, extended working hours, emotional labor, exposure to suffering, interpersonal demands, and responsibility for patient safety. These conditions may interfere with sleep, recovery, family life, and overall well-being. Research on hospital nurses has demonstrated measurable changes in fatigue and sleep across consecutive 12-hour shifts, underscoring the physiological burden associated with demanding schedules (4). A systematic review further showed that nurse fatigue is associated not only with adverse outcomes for nurses themselves but also with patient safety and organizational outcomes, highlighting the broader implications of compromised well-being among nursing personnel (5). Work environments and organizational cultures can also intensify or mitigate nurses' work-related stress, indicating that occupational well-being is partly determined by contextual and relational characteristics of the workplace (6). Likewise, a supportive practice environment and perceived organizational support have been associated with general well-being, occupational burnout, and turnover intention among nurses (7). These findings suggest that nurses' quality of life is influenced by multiple ecological levels and that occupational strain may extend beyond the workplace into family functioning and personal adjustment.

Evidence specifically addressing nurses' quality of life has consistently documented the importance of occupational and psychological risk factors. Burnout is strongly intertwined with nurses' quality of life, although differences in measurement approaches and dimensions assessed have created variability across studies (8). Among mental health nurses, professional quality of life has likewise emerged as a significant issue, with systematic evidence demonstrating the simultaneous relevance of compassion satisfaction, burnout, and secondary traumatic stress (9). Nurses' cognitive and emotional resources may also be important; for example, nurses' quality of life has been associated with COVID-19-related anxiety and cognitive flexibility, suggesting that adaptive psychological capacities may buffer the effects of stressful conditions (10). More broadly, achieving work-life balance among hospital nurses appears to depend on interacting individual, interpersonal, organizational, and sociocultural factors rather than on any single personal characteristic (11). Therefore, although professional conditions are crucial, the quality of nurses' family relationships and their families' capacity to adapt to stress may constitute equally important determinants of well-being.

The family is one of the most immediate and enduring social systems influencing emotional security, coping, behavioral regulation, interpersonal support, and everyday functioning. Family functioning generally refers to the effectiveness with which family members solve problems, communicate, perform roles, express and respond to emotions, regulate behavior, and maintain appropriate affective involvement.

Healthy functioning allows the family system to coordinate responsibilities, respond constructively to stressors, and provide practical and emotional resources to its members. Conversely, ineffective functioning can create chronic interpersonal strain and diminish individuals' capacity to cope with challenges encountered outside the family. Research has demonstrated the relevance of family functioning across diverse psychological and behavioral outcomes; for example, it has been implicated in models predicting substance-related tendencies and maladaptive academic behaviors (12). Changes in family developmental stages have also been associated with differences in family functioning, marital conflict coping styles, and cognitive flexibility, further illustrating the dynamic nature of family processes across the life course (13). Such evidence supports the view that family functioning is not a static background characteristic but an active psychosocial resource with implications for individual adjustment.

A substantial body of research indicates that family functioning is closely related to quality of life across different health and caregiving contexts. Among older adults, better family functionality has been associated with higher quality of life, emphasizing the protective role of supportive and adaptive family relationships (14). In families of children with intellectual disabilities, family functioning has been shown to mediate the relationship between caregiving burden and family quality of life, suggesting that the organization and relational quality of family life may shape how stress translates into well-being (15). Similarly, family functioning has been associated with health-related quality of life in stroke survivor–family caregiver dyads, demonstrating that family processes can influence the well-being of both individuals receiving care and those providing it (16). Among parents of children with mental illness, patterns of family functioning have also been related to health-related quality of life (17). In children and young adults with Marfan syndrome, family functioning has been linked to health-related quality of life (18), while research involving pediatric cancer survivors indicates that family functioning may interact with disease- and treatment-related factors in explaining quality-of-life outcomes (19). Together, these findings demonstrate that family functioning is relevant across a wide range of developmental, medical, and caregiving situations.

The importance of family functioning is further reinforced by intervention research. Family-focused and family-centered interventions aim to improve communication, support, coping, caregiving competence, and relational adaptation. A systematic review and meta-analysis of community-based family-focused interventions for families of children with chronic health conditions found that family-oriented approaches can improve dimensions of family functioning (20). Family-centered interventions for family caregivers have likewise demonstrated beneficial effects across multiple outcomes, illustrating the value of treating the family as a unit of care rather than focusing exclusively on one individual (21). In families of children with intellectual disability, family-centered care has been associated with improvements in outcomes relevant to both family processes and well-being (22). Similarly, psychosocial interventions in families affected by parental cancer may improve mental health and aspects of family functioning, although the magnitude and consistency of effects depend on intervention characteristics and family needs (23). These findings are especially relevant to nurses because persistent occupational demands may require families to reorganize roles, communication, childcare, household responsibilities, and emotional support in response to irregular work schedules.

However, the relationship between family functioning and quality of life may not be entirely direct. Family systems differ substantially in their ability to adjust to changing conditions and reorganize when faced with

stress. Family flexibility refers to the family's capacity to modify roles, rules, patterns of interaction, and decision-making structures in response to situational and developmental demands. Adequate flexibility allows families to accommodate change without losing stability, whereas excessive rigidity may prevent adaptation and excessive instability may undermine consistency. Studies have shown that cohesion and flexibility are relevant to diverse indicators of adjustment and interpersonal functioning (24). Family cohesion and flexibility have also been linked to academic vitality through meaning-related psychological processes, suggesting that flexible family systems can contribute to adaptive functioning beyond the family context itself (25). Among individuals with cancer, quality of life has been examined in relation to family flexibility and attachment patterns, further indicating the possible contribution of flexible family organization to well-being under conditions of significant stress (26). Although housing research addresses flexibility from a different disciplinary perspective, it similarly emphasizes that adaptable environments and family-responsive arrangements can contribute to quality of life, reinforcing the broader conceptual importance of responsiveness to changing family needs (27).

Psychological and relational flexibility may also influence how stress affects family systems. In families in which a parent is ill, psychological flexibility has been found to moderate the effects of youth caregiving and stress on adjustment and family functioning (28). At the family level, resilience research likewise emphasizes the ability to adapt, reorganize, maintain supportive communication, and mobilize resources in the face of adversity. A meta-analysis has shown a meaningful association between family resilience and mental health, supporting the idea that adaptive family processes are relevant to psychological well-being (29). Family communication also appears to contribute to resilience through psychosocial pathways; among parents of adolescents with depression, communication was related to family resilience through social support and psychological resilience (30). Parent-adolescent relationship quality has similarly been associated with affective well-being within families, illustrating how ongoing relational processes and individual emotional states are interconnected (31). For nurses who regularly encounter unpredictable schedules, high emotional demands, and work-family interference, flexibility may therefore serve as an important mechanism through which healthier family functioning translates into better quality of life.

Another potentially important mediating mechanism is family strengths. Family strengths refer to the resources and positive relational capacities that enable family members to sustain supportive relationships, overcome difficulties, and pursue growth. This construct commonly includes shared values, commitment to family stability and development, effective conflict resolution and communication, positive interaction and appreciation, and spending meaningful time together. Family strengths are conceptually distinct from the absence of dysfunction because they focus on positive competencies and resources that can actively support family adaptation. Evidence from Iranian research indicates that family empowerment or strength-related capacities are associated with psychological capital, meaning in life, and perceived social support (32). Family empowerment has also been examined in relation to behavioral self-efficacy, including drug-cessation self-efficacy among women with substance use disorders, suggesting that strengthened family resources may support adaptive personal change (33). These findings indicate that family strengths may function as a reservoir of emotional and practical resources that individuals can draw upon when confronting stress.

The relationship between family strengths and quality of life has also been documented in health-related populations. Among young breast cancer survivors, family beliefs and family strengths were associated with resilience and quality of life, indicating that supportive family resources may facilitate adaptive responses to major health-related stressors (34). Family characteristics have also been associated with the level of parental empowerment and family quality of life among families using early childhood intervention services (35). More generally, parents caring for children or young people with mental health difficulties report substantial needs for information, emotional support, recognition, and meaningful involvement in care, all of which highlight the importance of strengthening family resources and functioning (36). Longitudinal research among family caregivers of individuals with schizophrenia has further shown that family functioning may change over time, suggesting that family capacities can evolve in response to prolonged caregiving conditions and contextual stress (37). These findings support an understanding of family strengths as dynamic rather than fixed and as potentially responsive to both stress and supportive interventions.

The relevance of these variables to nurses becomes clearer when quality of life is conceptualized as the product of interacting work and family systems. Nurses must often reconcile professional responsibilities with marital, parental, and household roles. Shift work, fatigue, emotional exhaustion, and unpredictable clinical demands may reduce opportunities for shared family time, increase role conflict, and place pressure on communication and conflict-resolution processes. Conversely, well-functioning families may provide emotional security, effective redistribution of responsibilities, and supportive communication that can reduce the subjective burden of occupational demands. Family flexibility may enable nurses' households to adapt routines and roles around rotating shifts, while family strengths may provide commitment, appreciation, shared values, and constructive communication that sustain well-being despite workplace stress. This systems perspective is consistent with evidence showing that family functioning influences adjustment in multiple caregiving and health contexts and that supportive family processes can buffer stress-related consequences.

Empirical studies outside nursing also support indirect models linking family functioning to quality-of-life-related outcomes. In student populations, family functioning has been associated with quality of school life through psychological mediators such as academic self-efficacy (38). Studies of health behaviors and quality of life have likewise shown that personal and contextual behaviors can affect well-being in young adults, reinforcing the multidimensional and relational nature of quality of life (39). These findings are relevant because they demonstrate that family-level predictors may influence well-being through intermediate adaptive processes rather than solely through direct pathways. In the context of working nurses, family flexibility and family strengths represent theoretically plausible mediators because they reflect how a family adapts to demands and mobilizes relational resources. Investigating these mechanisms may therefore provide a more precise explanation of how family functioning is connected with quality of life.

Despite the expanding literature on nurse well-being, burnout, fatigue, work environment, family functioning, flexibility, resilience, and family-centered care, these domains have often been investigated separately. The nursing literature has predominantly emphasized occupational predictors of quality of life, whereas family studies have frequently focused on patients, caregivers, children, adolescents, or families affected by chronic illness. Relatively less attention has been paid to the structural relationships through

which family functioning may influence nurses' quality of life through specific adaptive family resources. This gap is particularly important among married female nurses, for whom professional responsibilities may coexist with substantial family and caregiving expectations. A structural model incorporating family functioning, family flexibility, family strengths, and quality of life can therefore provide a more integrated account of the family processes associated with nurses' well-being and may also identify potentially modifiable targets for family-oriented and occupational health interventions.

Accordingly, the present study aimed to examine the structural relationship between family functioning and quality of life, with family flexibility and family strengths as mediating variables, among female nurses employed in public hospitals in Khoy County.

Methods and Materials

Study Design and Participants

The present study employed a descriptive-correlational design and was conducted using structural equation modeling. The statistical population consisted of all female nurses employed in public hospitals in Khoy County during 2023 and 2024. Given that the nursing population constituted a finite and relatively homogeneous population, random sampling was employed. According to Kline (2015), the minimum sample size required for structural equation modeling is 200 participants. Therefore, to enhance the generalizability of the findings and account for the possibility of participant attrition, 210 female nurses were initially selected. After obtaining ethical approval under ethics code 1402.059 and the necessary permissions from the relevant medical sciences authorities, a complete list of female nurses was obtained from the Khoy medical sciences administration. Subsequently, 210 nurses were selected from this list using systematic random sampling. The questionnaires were then distributed among the selected participants, who were asked to complete the measures of quality of life, family functioning, family flexibility, and family strengths. It should be noted that two selected participants were on maternity leave; consequently, data were ultimately collected from 208 participants. The inclusion criteria were provision of informed consent, at least 2 years of work experience, and being married. The exclusion criteria included withdrawal of consent to continue participation for any reason, failure to complete the questionnaires, or incomplete questionnaire responses. Following approval of the research proposal and receipt of ethical approval and the necessary permissions from Guilan University of Medical Sciences and the medical sciences authorities of Khoy County, systematic random sampling was conducted. The researchers visited Ayatollah Khoei Hospital, Imam Khomeini Hospital, and Shahid Madani Hospital. After obtaining participants' informed consent and providing brief explanations regarding the study questions, objectives, procedures, and confidentiality of the information, the questionnaires were distributed to the nurses and subsequently collected at the designated time. Participation in the study was entirely voluntary, and participants had the right to withdraw at any stage. Participants were also informed that the collected information would be used exclusively for research purposes and reported only in aggregate form.

Data Collection Tools

The World Health Organization Quality of Life Questionnaire was developed in 1996 by a group of WHO experts through modification of the items of the 100-item version, resulting in a 26-item instrument. The

questionnaire comprises four subscales and an overall score. The subscales include physical health, psychological health, social relationships, and environmental health. Responses are rated on a 5-point Likert-type scale. Initially, a raw score is calculated for each subscale and subsequently transformed, using the appropriate scoring formula, into a standardized score ranging from 0 to 100. Higher scores indicate a higher quality of life. The WHOQOL Group considers the instrument to be a cross-cultural measure and therefore suitable for use across different cultural contexts (World Health Organization, 1996). In Iran, Nasiri et al. (2006) translated the instrument and reported evidence regarding its reliability and validity. A Cronbach's alpha coefficient of .84 indicated satisfactory internal consistency. Furthermore, factor analysis of the 26 items identified four subscales—physical health, psychological health, social relationships, and environment—providing evidence of construct validity. In another study, Nejat et al. (2006) examined the validity and reliability of the questionnaire by administering it to 1,167 residents of Tehran. Participants were divided into two groups: individuals with chronic illnesses and those without chronic illnesses. Test–retest reliability coefficients for the questionnaire subscales were .77 for physical health, .77 for psychological health, .75 for social relationships, and .84 for environmental health. In the present study, Cronbach's alpha for the Quality of Life Scale was .846.

The Family Assessment Device is a 60-item Likert-type questionnaire developed by Epstein et al. (1983) to assess family functioning based on the McMaster Model of Family Functioning (Veysi et al., 2025). The questionnaire assesses the dimensions of problem solving, communication, roles, affective responsiveness, affective involvement, behavior control, and general functioning. Items are rated on a 4-point Likert-type scale ranging from strongly agree to strongly disagree. Lower scores indicate healthier family functioning (Veysi et al., 2025). The scale has been reported to have an alpha coefficient of .75 and evidence of concurrent and predictive validity. Moreover, in a sample of 503 participants, a classification procedure correctly identified 67% of nonclinical families and 64% of clinical families (as cited in Veysi et al., 2025). Regarding reliability, Cronbach's alpha coefficients for its subscales ranged from .72 to .92, indicating relatively satisfactory internal consistency. In Iran, Najarian first translated, standardized, and normed the questionnaire in 1995 and reported a reliability coefficient of .93, which was statistically significant (as cited in Veysi et al., 2025). In the present study, Cronbach's alpha for the Family Functioning Scale was .784.

The Family Flexibility Scale was developed by Shakeri in 2003 (as cited in Soltani Banavandi et al., 2019). The Family Flexibility Questionnaire consists of 16 items and is completed by family members to determine the level of flexibility within the family on the basis of their responses. Responses are provided on a 5-point Likert-type scale comprising strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree, scored from 5 to 1, respectively (Soltani Banavandi et al., 2019). In this questionnaire, scores in the upper 50% of the distribution, corresponding to scores above 52, are classified as indicating a high level of family flexibility, whereas scores in the lower 50%, corresponding to scores below 52, are classified as indicating a low level of family flexibility. The reliability and validity of the questionnaire were confirmed in a study involving 48 participants. The internal consistency coefficient, calculated using Cronbach's alpha, was reported as .89 (Soltani Banavandi et al., 2019). Factor analysis identified a single general factor labeled flexibility, and the content validity of the questionnaire was also confirmed. In another stage, the questionnaire was administered to a different group, and its reliability was assessed using Cronbach's alpha,

yielding a coefficient of .93 (Soltani Banavandi et al., 2019). In the present study, Cronbach's alpha for the Family Flexibility Scale was .72.

The Family Strengths Scale developed by Sham et al. (2001) is a 20-item instrument designed to assess family strengths across the dimensions of values, commitment, conflict resolution/communication, positive interaction, and spending time together. Items are rated on a 5-point Likert-type scale ranging from strongly agree to strongly disagree. The minimum possible score is 20 and the maximum score is 100, calculated by summing the item scores. In Iran, Ghaffari first investigated the psychometric properties of this questionnaire in 2013. To evaluate internal consistency, data from 395 participants were analyzed. Cronbach's alpha was .91 for the total score, while coefficients for the subscales were .87 for conflict resolution/communication, .74 for positive interaction/appreciation, .73 for values, .80 for spending time together, .76 for commitment to growth, and .63 for commitment to stability, indicating satisfactory reliability (as cited in Khoshroo Roudbarki et al., 2023). The stability of the instrument and its subscales was assessed using a 2-week test–retest procedure with 50 participants. Test–retest coefficients were .85 for the total scale, .83 for conflict resolution and communication, .70 for positive interaction and appreciation, .69 for values, .77 for spending time together, .71 for commitment to growth, and .60 for commitment to stability, indicating acceptable temporal stability (as cited in Khoshroo Roudbarki et al., 2023). In the present study, Cronbach's alpha for the questionnaire was .92.

Data Analysis

Data were analyzed using structural equation modeling in SPSS version 26 and AMOS version 24. The significance of indirect effects was examined using the bootstrap method implemented through the Preacher and Hayes (2008) macro.

Findings and Results

The study included 208 female nurses employed in public hospitals in Khoy County. Their mean age was 36.82 years, the mean duration of marriage was 11.55 years, and the mean work experience was 12.48 years. Regarding educational attainment, 78.8% held a bachelor's degree and 21.2% held a master's degree. Furthermore, 55.3% had one child, 35.1% had two children, and 9.6% had no children. Table 1 presents the descriptive statistics, including the mean, standard deviation, skewness, and kurtosis, for family functioning, family flexibility, family strengths, and quality of life.

Table 1. Descriptive Statistics for the Study Variables

Variable	Subscale	Mean	SD	Skewness	Kurtosis
Family functioning	Problem solving	11.00	2.04	−0.03	−0.47
	Communication	14.91	1.43	−0.25	0.45
	Roles	20.96	2.13	−0.63	1.45
	Affective responsiveness	16.82	1.90	−0.28	0.36
	Affective involvement	27.17	3.25	0.29	−0.16
	Behavior control	23.67	2.58	0.32	−0.38
	General functioning	114.55	5.81	0.36	−0.12
Family flexibility	—	52.40	4.39	0.12	−0.27
Family strengths	Conflict resolution/communication	26.12	3.08	0.26	−0.77
	Positive interaction/appreciation	6.25	0.87	0.93	1.13
	Values	13.16	1.34	−0.38	0.31
	Spending time together	12.57	1.29	−0.35	0.21

	Commitment to growth	8.94	1.04	-0.21	-1.30
	Commitment to stability	9.14	1.48	-0.80	1.52
	Total	76.22	5.07	0.01	-0.39
Quality of life	Physical health	53.50	9.44	0.18	-0.36
	Psychological health	61.49	12.05	0.49	-0.43

The exogenous variable of family functioning had a mean of 114.55 and a standard deviation of 5.81. The mediating variables of family flexibility and family strengths had means of 52.40 and 76.22 and standard deviations of 4.39 and 5.07, respectively. The endogenous variable of quality of life had a mean of 65.98 and a standard deviation of 15.04. Table 2 presents the Pearson correlation coefficients among family functioning, family flexibility, family strengths, and quality of life.

Table 2. Correlation Matrix of the Study Variables

Scale	Family Functioning	Family Flexibility	Family Strengths	Quality of Life
Family functioning	1			
Family flexibility	.39**	1		
Family strengths	.32**	.21**	1	
Quality of life	.57**	.34**	.50**	1

Note. $p < .01$. $p < .05$.

According to the correlation matrix presented in Table 2, family functioning was positively and significantly associated with quality of life, family flexibility, and family strengths. Furthermore, family flexibility and family strengths were positively and significantly associated with quality of life. Before testing the research hypotheses using structural equation modeling, the required assumptions were examined. Missing data were addressed using the expectation-maximization procedure (Kline, 2015). Examination of multivariate outliers based on Mahalanobis distance indicated that no multivariate outliers were present. The skewness and kurtosis indices further showed that all variables met the assumption of univariate normality, with absolute skewness values below 3 and kurtosis values below 10. Multivariate normality was examined using Mardia's kurtosis coefficient and critical ratio, which were 4.03 and 2.31, respectively, both below the criterion value of 5. Thus, the assumption of multivariate normality was also satisfied. Finally, tolerance and variance inflation factor (VIF) indices were examined to assess multicollinearity. VIF values ranged from 1.08 to 2.34, while tolerance values ranged from .42 to .92, indicating the absence of problematic multicollinearity among the study variables. Overall, the findings indicated that the assumptions required for conducting structural equation modeling were satisfied. After establishing the major assumptions of structural equation modeling, the primary research hypothesis was examined based on the two-step approach proposed by Anderson and Gerbing (1988). In the first step, confirmatory factor analysis was used to evaluate the fit of the measurement model. In the second step, the proposed structural model was tested using structural equation modeling. The proposed model was evaluated using covariance-based structural equation modeling in AMOS version 24, and model parameters were estimated using maximum likelihood estimation. After selecting the indicators corresponding to the hypothesized research model, an overall confirmatory factor analysis was performed for the study variables, including family functioning, family strengths, and quality of life. This procedure made it possible to evaluate the adequacy of the selected measurement model for the latent variables by examining the confirmatory factor analysis fit indices.

Table 3. Goodness-of-Fit Indices for the Confirmatory Factor Analysis of the Proposed Model

χ^2	df	<i>p</i>	CMIN/df	RMSEA	PNFI	CFI	GFI
221.27	101	.001	2.19	.075	.565	.917	.941

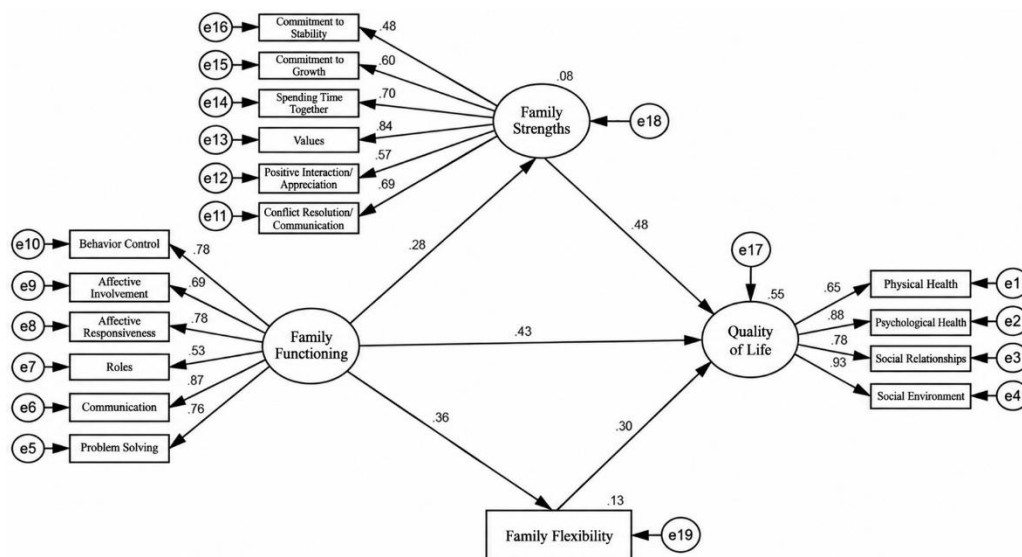
The results of the confirmatory factor analysis indicated that all fit indices supported a good fit of the measurement model to the data. Moreover, all observed variables had factor loadings greater than .30 and were statistically significant at $p < .001$.

Before examining the structural coefficients, the goodness of fit of the proposed model was assessed. The fit of the proposed model was evaluated using the specified goodness-of-fit indices. As shown by the results presented in Table 4, the fit indices indicated that the proposed model demonstrated a good fit to the data. Therefore, the proposed model exhibited satisfactory goodness of fit. The goodness-of-fit indices for the proposed structural model are presented in Table 4.

Table 4. Goodness-of-Fit Indices for the Proposed Structural Model

Model	χ^2	df	<i>p</i>	CMIN/df	RMSEA	PNFI	CFI	GFI
Proposed model	255.66	151	< .001	2.22	.070	.563	.916	.939

The R^2 index represents the proportion of variance explained in endogenous latent variables. Chin (1998) characterized R^2 values of .67, .33, and .19 in structural equation modeling as substantial, moderate, and weak, respectively. The coefficient of determination for quality of life was .551, indicating that the exogenous and mediating variables—family functioning, family flexibility, and family strengths—collectively explained 55.1% of the variance in quality of life. This proportion of explained variance was considered substantial. Table 5 presents the standardized path coefficients, while Figure 1 illustrates the structural model of the study.

**Figure 1. Final Structural Model**

Based on the estimated indices, the findings indicated that the structural model examining the mediating roles of family flexibility and family strengths in the relationship between family functioning and quality of life among women employed in public hospitals demonstrated an acceptable fit. In Figure 1, the values displayed on the paths represent path weights or standardized beta coefficients. Among these coefficients,

the largest coefficient ($\beta = .481$) corresponded to the path from family strengths to quality of life, whereas the smallest coefficient ($\beta = .282$) corresponded to the path from family functioning to family strengths. The results regarding the direct relationships among the study variables in the proposed model indicated that all path coefficients were statistically significant in the total sample. The standardized coefficients for all paths and their corresponding critical ratios in the proposed model are presented in Table 5.

Table 5. Standardized Path Coefficients for the Proposed Model

Path	Standardized Coefficient (β)	SE	Critical Ratio	<i>p</i>
Family functioning → Quality of life	.430	.103	5.570	< .001
Family functioning → Family flexibility	.358	.084	4.639	< .001
Family functioning → Family strengths	.282	.036	3.521	< .001
Family flexibility → Quality of life	.301	.048	3.893	< .001
Family strengths → Quality of life	.481	.117	6.685	< .001

The results concerning the mediating relationships were subsequently examined using bootstrap analysis and are presented in Table 6. The proposed model in the present study contained two indirect, or mediated, pathways. Bootstrap analysis was used to determine the statistical significance of each mediating relationship and the indirect effect of the exogenous variable on the endogenous variable through the mediators. The bootstrap results for the mediating pathways in the proposed model are presented in Table 6. According to the findings, family functioning had a positive and statistically significant direct effect on quality of life ($\beta = .430$, $p < .001$). Thus, family functioning had a direct effect on quality of life, supporting Hypothesis 1.

Table 6. Bootstrap Results for the Indirect Paths in the Proposed Model

Path	Indirect Effect	SE	Lower Bound	Upper Bound	<i>p</i>
Family functioning → Family flexibility → Quality of life	.1080	.0321	.0644	.1592	< .001
Family functioning → Family strengths → Quality of life	.1344	.0590	.0744	.2236	< .001

As shown in Table 6, the lower bound of the confidence interval for family flexibility as a mediator between family functioning and quality of life was .0644, and the upper bound was .1592. The confidence level was 95%, and 5,000 bootstrap resamples were used. Because zero was not contained within this confidence interval, the indirect effect was statistically significant. Thus, family flexibility mediated the relationship between family functioning and quality of life, with an indirect effect of .1080. Therefore, Hypothesis 2 was supported. As also shown in Table 6, the lower bound of the confidence interval for family strengths as a mediator between family functioning and quality of life was .0744, while the upper bound was .2236. The confidence level was 95%, with 5,000 bootstrap resamples. Because zero was not contained within this confidence interval, the indirect effect was statistically significant. Therefore, family strengths mediated the relationship between family functioning and quality of life, with an indirect effect of .1344.

Discussion and Conclusion

The present study examined the structural relationship between family functioning and quality of life among female nurses employed in public hospitals, with family flexibility and family strengths considered as mediating variables. The findings supported the proposed structural model and indicated that family functioning had a significant direct effect on quality of life ($\beta = .430$). Family functioning also significantly predicted family flexibility ($\beta = .358$) and family strengths ($\beta = .282$). In addition, family flexibility ($\beta =$

.301) and family strengths ($\beta = .481$) had significant direct effects on quality of life. The bootstrap analysis further showed that the indirect effect of family functioning on quality of life through family flexibility was significant ($\beta = .1080$), as was the indirect effect through family strengths ($\beta = .1344$). The overall model explained 55.1% of the variance in quality of life, indicating that family-related processes accounted for a substantial proportion of differences in nurses' quality of life. These findings support a systemic interpretation of nurses' well-being in which family functioning influences quality of life both directly and indirectly through adaptive family processes and positive family resources.

The significant direct effect of family functioning on quality of life is consistent with previous research indicating that healthy family processes are closely associated with subjective and health-related well-being. Family functioning encompasses several interconnected domains, including problem solving, communication, role organization, affective responsiveness, affective involvement, and behavioral control. When these dimensions operate effectively, family members are better able to coordinate responsibilities, exchange emotional support, resolve interpersonal tensions, and respond constructively to stressful situations. Studies conducted in different health-related populations have similarly documented an association between family functioning and quality of life. For example, family functionality has been associated with quality of life among older adults, suggesting that cohesive and effective family systems may provide both emotional and practical resources that promote well-being (14). Likewise, family functioning has been associated with health-related quality of life in stroke survivor–caregiver dyads, indicating that the quality of family interaction affects not only individuals experiencing health problems but also close family members involved in care (16). Comparable findings have also been reported among parents of children with mental illness, where family functioning was related to health-related quality of life (17).

The present finding may also be explained by the specific occupational conditions experienced by nurses. Nursing involves demanding schedules, emotional labor, intensive interpersonal contact, and responsibility for patients' safety and recovery. Fatigue associated with long and repeated work shifts can accumulate rapidly and disrupt sleep, recovery, and functioning outside the workplace (4). Moreover, nurse fatigue has been systematically associated with negative outcomes for nurses, patients, and healthcare organizations (5). Under such circumstances, the family can serve as an important source of emotional regulation, instrumental assistance, and recovery. A family system characterized by effective communication and flexible role allocation may help nurses manage the spillover of occupational stress into home life. This interpretation is also consistent with findings showing that nurses' well-being is influenced by their practice environment, perceived organizational support, burnout, and other psychosocial conditions (7). Although these variables arise in the workplace, their consequences are likely to interact with family resources, especially among married female nurses who simultaneously manage occupational and domestic responsibilities.

The positive relationship between family functioning and quality of life is also aligned with studies emphasizing that family processes can influence adaptation in the presence of illness, caregiving burden, or sustained stress. Family functioning has been shown to mediate the relationship between care burden and family quality of life among caregivers of children with intellectual disabilities (15). In children and young adults with Marfan syndrome, better family functioning has similarly been associated with more favorable health-related quality of life (18). Research involving pediatric cancer survivors also suggests that family

functioning interacts with disease- and treatment-related factors in shaping quality of life (19). Together, these studies indicate that family functioning is not merely a background characteristic but an active psychosocial mechanism through which individuals interpret, manage, and adapt to stressful life conditions. For nurses, an effective family system may reduce the psychological impact of occupational burden by creating a more predictable, supportive, and emotionally responsive home environment.

Another finding of the present study was that family functioning significantly predicted family flexibility. This result is conceptually expected because flexibility is one of the principal adaptive capacities through which a family system responds to developmental transitions and external pressures. Families with healthier patterns of communication, problem solving, and role organization are more likely to reorganize their routines when circumstances change. Previous research has emphasized the importance of family flexibility in adaptive functioning. Family cohesion and flexibility have been associated with social intimacy among female university students (24), and family flexibility has also been shown to predict academic vitality through meaning in life (25). In health-related settings, family flexibility has been investigated in relation to quality of life among individuals with cancer (26). Furthermore, changes across family developmental stages have been associated with family functioning, coping with marital conflict, and cognitive flexibility, indicating that adaptation within the family system is closely connected with broader psychological and relational functioning (13). These studies support the present finding that better family functioning is associated with a greater capacity for flexibility.

The significant direct effect of family flexibility on quality of life provides further evidence that adaptive family reorganization may be especially important for nurses. Nurses often work rotating shifts, night shifts, weekends, and extended hours, which can interfere with regular family routines. In such circumstances, rigid patterns of household responsibility or inflexible expectations regarding family roles may intensify stress and work–family conflict. By contrast, flexibility allows family members to redistribute responsibilities, modify routines, tolerate changes in availability, and adjust expectations in response to occupational demands. This may reduce interpersonal conflict and preserve emotional support despite changing work schedules. The importance of flexibility as an adaptive psychological resource has been demonstrated in other contexts as well. Psychological flexibility has been shown to moderate the impact of caregiving and stress on adjustment and family functioning in families affected by parental illness (28). Similarly, nurses' quality of life has been associated with cognitive flexibility, indicating that the capacity to adapt cognitively may contribute to well-being under stressful occupational conditions (10). Although family flexibility and cognitive flexibility are distinct constructs, both reflect an adaptive ability to modify responses when circumstances change.

The mediating role of family flexibility was also supported by the bootstrap analysis. Family functioning had a significant indirect effect on quality of life through family flexibility, indicating that one pathway through which healthy family functioning may enhance nurses' quality of life is by increasing the family system's capacity to adapt to changing demands. This result is compatible with broader resilience-oriented models of family adaptation. Family resilience has been significantly associated with mental health across studies, underscoring the importance of adaptive family processes in psychological well-being (29). Family communication has also been linked with family resilience through social support and psychological resilience among parents of adolescents with depression (30). These findings suggest that effective

communication and family functioning may generate adaptive resources that, in turn, improve well-being. In the context of nurses, healthier family functioning may promote flexible adjustment of roles, expectations, and patterns of interaction, thereby reducing the adverse impact of occupational stress on quality of life.

The findings further demonstrated that family functioning significantly predicted family strengths. Family strengths involve positive relational resources such as shared values, commitment, effective communication and conflict resolution, appreciation, positive interaction, and spending meaningful time together. A well-functioning family is likely to provide the interpersonal context in which these strengths are developed and sustained. The present result is consistent with studies linking family empowerment and positive family resources with psychological well-being and supportive interpersonal processes. For example, family empowerment has been associated with psychological capital, meaning in life, and perceived social support (32). Family empowerment has also been related to self-efficacy in behavioral change contexts, indicating that stronger family resources may facilitate individual adaptive functioning (33). Family-centered care research similarly highlights the importance of strengthening family competence, participation, and relational capacity in improving outcomes for family members (21, 22).

Among all direct paths in the proposed model, the effect of family strengths on quality of life was the strongest ($\beta = .481$). This finding suggests that the presence of positive family resources may be particularly important for nurses' well-being. The result is consistent with research among young breast cancer survivors showing that family beliefs and family strengths were associated with individual resilience and quality of life (34). It is also compatible with evidence showing that family characteristics are associated with parental empowerment and family quality of life among families receiving early childhood intervention services (35). Positive family interactions may promote quality of life by creating a sense of emotional security, belonging, appreciation, and reliable support. For nurses, who may encounter distressing events, high responsibility, and emotionally challenging patient interactions, such family resources may help facilitate psychological recovery after work and reduce the cumulative impact of professional stress.

The mediating role of family strengths was likewise significant. Family functioning indirectly influenced quality of life through family strengths, suggesting that healthier family functioning may enhance quality of life partly because it produces or reinforces constructive family resources. Effective problem solving, communication, and role performance can facilitate mutual trust, commitment, positive interaction, and shared time, all of which may strengthen a nurse's capacity to manage occupational pressures. This interpretation is consistent with research suggesting that family-focused interventions can improve family functioning among families facing chronic health conditions (20). Systematic evidence further indicates that family-centered interventions can benefit family caregivers across multiple psychosocial outcomes (21). In families affected by parental cancer, psychosocial interventions have also shown potential for improving mental health and family functioning (23). These findings reinforce the idea that family strengths are modifiable resources rather than fixed characteristics and may therefore represent meaningful targets for intervention.

The overall explanatory power of the structural model also deserves attention. Family functioning, family flexibility, and family strengths jointly explained 55.1% of the variance in quality of life, indicating that family-related processes accounted for a substantial component of nurses' well-being. Nevertheless, the remaining unexplained variance highlights the multidimensional nature of quality of life. Nurses' well-being

is also shaped by burnout, fatigue, workplace culture, organizational support, work–life balance, sleep, and other personal and contextual factors. Systematic evidence has shown a consistent relationship between burnout and nurses' quality of life (8), while professional quality of life among mental health nurses is influenced by compassion satisfaction, burnout, and secondary traumatic stress (9). Work-related stress is also shaped by organizational culture and characteristics of the nursing work environment (6). From a broader ecological perspective, quality of life reflects the combined influence of individual, family, workplace, and social conditions (1, 3). Therefore, the present findings should be interpreted as identifying family functioning and adaptive family resources as important components within a broader network of determinants.

The results also correspond with a work–life balance perspective. Nurses' ability to maintain equilibrium between professional and family responsibilities depends on factors operating across personal, interpersonal, organizational, and social levels (11). Healthy family functioning, flexibility, and family strengths may help protect quality of life when occupational schedules disrupt family routines. Likewise, positive relationship quality within families has been associated with affective well-being, demonstrating the close interdependence between relational processes and emotional states (31). Parents and family members coping with mental health difficulties also report substantial needs for support, communication, and participation, emphasizing that family well-being depends strongly on relational resources and shared coping (36). Thus, the present findings extend previous family and health research by demonstrating that these family-level processes are also relevant to the quality of life of working nurses.

Overall, the findings support a model in which family functioning contributes to female nurses' quality of life through multiple pathways. Effective family functioning appears to provide a direct foundation for better well-being while also facilitating flexibility and strengthening positive family resources. Flexibility allows the family to reorganize effectively in response to occupational and life demands, whereas family strengths provide emotional, relational, and practical resources that support coping and recovery. The stronger direct effect observed for family strengths suggests that positive family capacities may be especially salient for nurses facing persistent occupational demands. Taken together, these results reinforce the need to conceptualize nurses' quality of life not solely as an occupational or individual issue but as an outcome influenced by the interaction between workplace pressures and the adaptive functioning of the family system.

The present study had several limitations. First, the cross-sectional and correlational design does not permit causal conclusions regarding the relationships among family functioning, family flexibility, family strengths, and quality of life. Second, the study was conducted exclusively among married female nurses employed in public hospitals in Khoy County, which may limit the generalizability of the findings to male nurses, unmarried nurses, nurses working in private hospitals, or healthcare professionals in other geographical regions. Third, all variables were assessed through self-report questionnaires, which may increase the likelihood of common-method variance, social desirability bias, and response bias. Fourth, some potentially important variables, including workload, shift type, number of night shifts, burnout, occupational stress, perceived organizational support, socioeconomic status, and spouse support, were not included in the model. Finally, the family variables were assessed from the perspective of nurses only, and information from spouses or other family members was not collected.

Future studies are recommended to use longitudinal and prospective designs to clarify the temporal and potentially causal relationships among family functioning, family flexibility, family strengths, and quality of life. Replication of the structural model in larger and more diverse samples, including male nurses, unmarried nurses, nurses employed in private hospitals, and nurses from different cities and cultural contexts, would improve the external validity of the findings. Future studies could also incorporate occupational variables such as burnout, work–family conflict, shift work, workload, sleep quality, organizational support, resilience, and job stress into more comprehensive structural models. Dyadic and family-level research involving nurses and their spouses or other family members may provide a more accurate understanding of family functioning and shared adaptation. Experimental and intervention studies are also needed to determine whether improving family communication, flexibility, conflict resolution, and family strengths can produce measurable improvements in nurses' quality of life over time.

Healthcare administrators, occupational health professionals, psychologists, and counselors working with nurses should consider family-related factors when designing programs intended to improve nurses' quality of life. Family-oriented educational and counseling programs can focus on improving communication, constructive problem solving, flexible division of household responsibilities, conflict management, positive interaction, appreciation, and meaningful shared time. Hospitals can also support nurses' family functioning by developing more predictable scheduling practices, reducing unnecessary fluctuations in work shifts, facilitating access to psychological and family counseling services, and considering family responsibilities when possible in workforce planning. Screening nurses experiencing low quality of life for difficulties in family functioning and adaptation may help identify those who could benefit from targeted support. Integrating family-strengthening strategies with workplace-based interventions may provide a more comprehensive approach to improving nurses' psychological well-being, family adjustment, and overall quality of life.

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Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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