



Quality of Family Life During COVID-19 Pandemic and Relevance Variables

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ABSTRACT

The current study investigated the quality of life among Saudi families during the COVID-19 pandemic. A descriptive survey approach was employed, wherein a family quality of life questionnaire was administered to a randomly selected sample of 274 Saudi citizens in the Qassim region. The study examined significant differences in family quality of life across four dimensions: (A) health and physical, (B) emotional and psychological, (C) family and social relations, and (D) quality of education and study of children. These dimensions were analyzed based on demographic variables, including parents' age, educational levels, employment status, number of family members, family income, and area of residence. The collected data illustrated that the quality of life of Saudi families during the COVID-19 pandemic was at an average level. The highest reported quality was in the health and physical aspect (A), followed by the emotional and psychological aspect (B). Family and social relations (C) ranked third, followed by the quality of education and study of children (D). Furthermore, the overall family quality of life for parents aged 40 years and above was significantly better than for those aged 30–40 or under 30 years. Additionally, the quality of children's education and study did not differ significantly according to the wife's education, parents' employment, number of children, region of residence, or the husband's education. However, a significant difference emerged in the emotional and psychological quality of life in favor of families where the husband held a university degree or higher. In conclusion, higher educational attainment appears to be a protective factor, and better education is recommended to support all aspects of family life during crises.

Keywords: Quality of health and physical life, quality of emotional and psychological life, quality of family and social relations, quality of education and study for children, COVID-19 pandemic.



Introduction

The outbreak of COVID-19, late in 2019, was a world health pandemic that caused a real crisis for countries and societies. This led the World Health Organization (WHO) to announce that COVID-19 had become a serious global epidemic necessitating international measures in an attempt to control it and limit its spread. One of the most prominent measures taken by states was banning gatherings and parties, and obligating their citizens to practice social distancing of at least two meters. Governments also issued curfews in many cities and banned travel (Saudi Press Agency & Royal News, 2020). Such measures had ramifications across all sectors of the economic, political, social, and psychological life of people, entailing changes in various features of behavioral, emotional, cognitive, and social life. The way society members dealt with and behaved toward everything also changed (Atta, 2021).

Consequences of the pandemic included the closure of schools and stores and the paralysis of daily life in almost all parts of the world. In addition, there were severe political and economic consequences of the COVID-19 pandemic. It significantly affected family life (Ben Braik, 2021), forcing individuals to move to a new stage of life characterized by new requirements and needs. Consequently, contentment appeared when needs were satiated, and discontent emerged when they were not, largely depending on the availability of an appropriate level of quality of life (Al-Sioufi, 2020). As a result of this epidemic, many individuals lived in a state of panic, stress, and depression. A study conducted in Jordan in 2020 during the COVID-19 pandemic indicated that more than 80% of participants suffered from disturbing thoughts, feelings of fear, tension, and psychosomatic effects. The level of impact on mental health was moderate to severe (Alsalem et al., 2020). Pressures also affected the quality of life of individuals. The imposition of quarantine, curfews, and other preventive measures exposed all groups of societies to unprecedented emergency changes, including families, health and educational institutions, and other groups (El-Feki & Aboul-Fotouh, 2020). A study conducted in China during the early epidemic period reported that 52.1% of participants felt terrified and anxious due to the epidemic (Zhang & Ma, 2020).

The concept of quality of life has garnered great interest and has grown rapidly in psychology research during the 21st century (Al-Aitan et al., 2021). Still, defining the concept is a difficult task because specialists in various scientific disciplines have considered the study of quality of life as their own, defining it from their specialized perspectives. Therefore, no single specific definition has been universally agreed upon (Badr & Ismail, 2017). The World Health Organization has defined quality of life as the individual's perception of their position in life in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns (WHO, 2020). Quality of life is inherently related to the physical, psychological, and social environment in which the individual lives (Al-Mansi & Kazem, 2006). Additionally, Kazem and Al-Bahadli (2006) indicate that quality of life is defined in light of two basic dimensions: the subjective dimension and the objective dimension. The Encyclopedia of Psychology defines quality of life



as a multidimensional concept across seven dimensions: emotional balance, general physical health, family stability, continuity of social relations outside the family, economic stability, occupational stability, and physical compatibility (Peterman & Cella, 2000).

Recently, interest in studying the quality of family life has increased due to its importance in ensuring children develop well on social, emotional, and psychological levels, thereby improving their mental health. The importance of the family emerges through the fulfillment of essential needs, including material needs like housing, emotional needs such as warmth and acceptance, educational needs, and the need for protection and security (Habri & Yahya, 2018).

Given that the world has experienced profound effects from the COVID-19 pandemic, the current study is concerned with the impact of the pandemic on the quality of family life. Samlani et al. (2020) found that COVID-19 affected quality of life moderately. Al-Salmi (2020) illustrated that the negative effects on the Saudi family were generally weak. Khalaf and Al Saeed (2021) showed that psychological problems affected the sample members to a moderate degree. Al-Aitan et al. (2021) found an average quality of life impact during the pandemic, with the age group over 50 showing a better quality of life (mean = 3.38), and graduate-level education showing the highest quality of life. Yee et al. (2021) illustrated that depression levels negatively impacted quality of life across all dimensions.

Therefore, the importance of this research lies in its aim to help families and society achieve a high quality of family life in light of the conditions imposed by the COVID-19 pandemic. The main objectives were to recognize the quality of life levels for Saudi families during the COVID-19 pandemic and to identify statistically significant differences in family quality of life scales based on relevant demographic variables.

Research Methodology

The current study relied on the descriptive approach, which investigates the phenomenon as it exists in reality through the survey method, to reveal the reality of family quality of life in light of the COVID-19 pandemic. All participants gave informed consent via the statement: "I am aware that my responses are confidential, and I agree to participate in this survey". Appropriate protocols for protecting all participants' rights and privacy were utilized, with full disclosure of study requirements. Participants were informed that their data would not be released without permission and that they could withdraw at any time without giving a reason.

The current study includes the following limits:

- **Spatial limits:** Qassim region.
- **Human limits:** Saudi families living in the Qassim region.
- **Time limits:** The months of January–March 2021.
- **Objective limits:** Quality of family life, comprising four categories: (A) health & physical, (B) emotional & psychological, (C) family & social relations, and (D) education & study of children.



Study tool: To achieve the objectives, related studies were reviewed, and a questionnaire was prepared consisting of three parts. The first included primary demographic data: place of residence, age of spouses, education level, occupation, monthly family income, and number of children. The second presented 24 phrases on quality of life divided into the four aforementioned categories, each containing six phrases.

Validity and Reliability of the Tool

1. Apparent honesty (Arbitrators' validity): The tool was presented to 10 arbitrators in the fields of housing, home management, and psychology. Based on their reports, the final tool was prepared.

2. Internal consistency: The tool was applied to a pilot sample of 30 individuals outside the main study sample. Pearson's correlation coefficients were calculated between the scores of each phrase and the total score of its respective category. As shown in Table (A), all correlation coefficients were positive and statistically significant at the 0.01 level, indicating the appropriateness of each statement in measuring its category.

Table (A): Pearson's correlation coefficients between each phrase and the total score of its category

A: Health & Physical	Corr.	B: Emotional & Psych.	Corr.	C: Family & Social	Corr.	D: Education	Corr.
1	**0.533	7	**0.788	13	**0.689	19	**0.746
2	**0.609	8	**0.787	14	**0.625	20	**0.756
3	**0.571	9	**0.707	15	**0.643	21	**0.780
4	**0.627	10	**0.817	16	**0.709	22	**0.651
5	**0.676	11	**0.845	17	**0.748	23	**0.681
6	**0.561	12	**0.845	18	**0.729	24	**0.610

** Significant at 0.01 level or less.

3. Reliability (Stability): To verify stability, Cronbach's Alpha coefficients were extracted for the dimensions and the tool as a whole. Table (B) illustrates that the stability coefficients ranged from 0.740 to 0.888 for individual dimensions, and 0.771 for the tool as a whole. These coefficients are statistically acceptable, indicating appropriate stability.

Table (B): Tool stability using Cronbach's alpha coefficient

Dimension	Paragraph number	Cronbach's alpha coefficient
A; health & physical	6	0.823
B; emotional & psychological	6	0.888
C; Family & social relations	6	0.740
D; Education & study of children	6	0.796
Whole tool	24	0.771



Statistical Manipulations

The Statistical Package for the Social Sciences (SPSS) was used to analyze the data. Descriptive statistics (arithmetic means and standard deviations) were utilized. Table (C) shows the interpretation key for the arithmetic averages used to determine the quality of life levels.

Table (C): Interpretation of the results according to the arithmetic averages

Arithmetic mean	1 – 1.80	Above 1.80 – 2.60	Above 2.60 – 3.40	Above 3.40 – 4.20	Above 4.20 to 5.0
Quality of life level	Very poor	Poor	Medium	High	Very high

To test for significant differences across demographic variables, non-parametric tests (Mann-Whitney U test and Kruskal-Wallis H test) were primarily employed due to the ordinal nature of the Likert-scale data and the unequal sample sizes across the demographic subgroups. The use of non-parametric tests is methodologically justified and highly recommended in social science research when dealing with ordinal data and when group sizes are uneven, as they do not assume a normal distribution of the data (Corder & Foreman, 2011; Vargha & Delaney, 1998). For comparing two independent groups (educational level of parents), the Independent Samples T-test was utilized.

Results

The current study measured the quality of life levels for Saudi families during the COVID-19 pandemic across four categories: (A) health & physical, (B) emotional & psychological, (C) family & social relations, and (D) education & study of children.

Firstly: Descriptive Data Analysis

1. Place of residence, spouse's age, family monthly income, and number of children

The collected data are based on a total of 274 participants. Table (1) details the distribution of these demographic variables. Regarding the place of residence, 215 participants (78.5%) lived in a city, while 59 (21.5%) lived in a governorate. The age distribution shows that the majority of spouses were 40 years old and above (58.8%), followed by those aged 30 to less than 40 (32.5%), and those under 30 (8.7%). Monthly family income data revealed that about 68% earned 10,000 Saudi Riyals or more per month, while 9.1% earned less than 5,000 Riyals. Regarding the number of children, 45.3% of families had 4-6 children, 40.5% had 1-3 children, and 14.2% had more than 6 children.

**Table (1): Sample distribution according to place of residence, spouse's age, monthly income, and number of children**

Variable	Number	Percentage (%)
Place of residence		
City	215	78.5
Governorate	59	21.5
Total	274	100
Age of spouses		
Under 30 years old	24	8.7
30 to less than 40 years old	89	32.5
40 and above	161	58.8
Total	274	100
Monthly income		
Less than 5,000 SR	25	9.1
5,000 – <10,000 SR	61	22.3
10,000 – <15,000 SR	91	33.2
15,000 – 20,000 SR	44	16.1
>20,000 SR	53	19.3
Total	274	100

2. Education level and couple's job

Table (2) demonstrates the educational levels and job statuses for both wives and husbands. Most participants had a university qualification or higher (72.6% for wives and 62.4% for husbands). Regarding employment, 57.7% of husbands and 40.5% of wives worked in government jobs. A significant portion of wives (37.6%) reported having no job, compared to only 2.9% of husbands.

Table (2): Description of the study sample according to educational level and job variable

Variable	Wife N	Wife %	Husband N	Husband %
Education levels				
Literate	3	1.1	0	0
Primary	6	2.2	4	1.5
Middle	11	4.0	25	9.1
Secondary	55	20.1	74	27.0
University	177	64.6	131	47.8
Postgraduate	22	8.0	40	14.6
Total	274	100	274	100
Jobs				
Government	111	40.5	158	57.7
Private sector	19	6.9	28	10.2
Self-employed	5	1.8	26	9.5
Retired	36	13.1	54	19.7
None	103	37.6	8	2.9



Secondly: Analytical Data Analysis

1. The overall quality of life for Saudi participating families

Table (3) indicates that the overall quality of life for Saudi families during the COVID-19 pandemic was at a Medium (Average) level, with a mean of 3.26. The highest quality of life was seen in the health and physical dimension (mean = 3.46, High level), followed by emotional and psychological (mean = 3.32, Medium level), family and social relations (mean = 3.21, Medium level), and finally the quality of education and study for children (mean = 3.04, Medium level).

Table (3): Arithmetic averages and standard deviations of the quality of life scale

Dimensions	Arithmetic mean	SD	Level of quality	Rank
A; health & physical	3.46	0.476	High	1
B; emotional & psychological	3.32	0.973	Medium	2
C; Family & social relations	3.21	0.564	Medium	3
D; Education & study of children	3.04	0.867	Medium	4
Averaged quality of life as a whole	3.26	0.464	Medium	—

2. Differences based on the area of living

A Mann-Whitney test was used to verify differences based on the region of residence (city vs. governorate). As shown in Table (4), the Z-values ranged between 0.079 and 0.960, with significance levels between 0.33 and 0.93 ($P > 0.05$). This indicates that the area of living did not significantly affect the quality of life among the participating families.

Table (4): Differences between life scale dimensions due to the area of living (city, governorate)

Dimension	Area	N	Mean	SD	Avg. Rank	Z-Value	Sig.
A; health & physical	City	215	3.47	0.47	139.89	0.960	0.33
	Governorate	59	3.40	0.47	128.78		
B; emotional & psych.	City	215	3.32	0.95	138.56	0.423	0.67
	Governorate	59	3.31	1.04	133.64		
C; Family & social	City	215	3.21	0.54	137.30	0.079	0.93
	Governorate	59	3.22	0.62	138.22		
D; Education & study	City	215	3.01	0.85	135.47	0.814	0.41
	Governorate	59	3.13	0.80	144.90		
Quality of Life Scale	City	215	3.25	0.45	136.80	0.277	0.78
	Governorate	59	3.26	0.49	140.03		



3. Differences based on the age of parents

A Kruskal-Wallis test was conducted to examine differences based on the parents' age. Table (5) illustrates that the overall quality of life differed significantly according to age (Kruskal-Wallis = 6.824, $P = 0.033$). Subsequent pairwise comparisons using the Mann-Whitney test showed that parents aged 40 and above had a significantly higher overall family quality of life compared to younger groups. However, when examining each dimension individually, the differences did not reach statistical significance.

Table (5): Differences in life scale dimensions due to the age of parents

Measure	Avg. Rank <30 (n=24)	Avg. Rank 30-40 (n=89)	Avg. Rank >40 (n=161)	Kruskal Wallis	Sign.
A; health & physical	112.50	132.44	144.02	3.888	0.143
B; emotional & psych.	123.40	127.78	144.98	3.548	0.170
C; Family & social	114.56	138.24	140.51	2.276	0.320
D; Education & study	132.42	122.04	146.80	5.761	0.056
Quality of Life Scale	114.19	125.38	147.68	6.824	0.033*

4. Differences based on monthly family income

Table (6) shows the results of the Kruskal-Wallis test for monthly income. The values ranged between 1.942 and 8.418, with all significance levels ($P > 0.05$), indicating no statistically significant differences in the overall quality of life or its dimensions based on income. This suggests that high-income and low-income families reported similar quality of life levels during the pandemic.

Table (6): Differences in life scale dimensions due to monthly family income

Monthly income	N	Rank A	Rank B	Rank C	Rank D	Rank Overall
<5000 SR	25	116.04	129.58	126.88	153.96	133.68
5000-<10000 SR	61	141.27	123.48	132.76	123.70	125.00
10000-<15000 SR	91	136.53	140.34	142.97	125.21	133.05
15000-20000 SR	44	140.55	144.52	130.11	158.01	151.68
>20000 SR	53	142.42	146.67	144.71	149.70	149.56
Kruskal Wallis		2.281	3.345	1.942	8.418	4.504
Sign.		0.684	0.502	0.746	0.058	0.342

5. Differences based on the number of children

As presented in Table (7), the Kruskal-Wallis test indicated no statistically significant differences ($P > 0.05$) in the overall quality of life or its dimensions based on the number of children a family has.

**Table (7): Differences in life scale dimensions due to the number of children**

Dimension	Rank 1-3 (n=111)	Rank 4-6 (n=124)	Rank >6 (n=39)	Kruskal Wallis	Sign.
A; health & physical	133.52	133.28	162.26	4.491	0.106
B; emotional & psych.	132.63	137.33	151.90	1.714	0.424
C; Family & social	133.05	141.36	137.87	0.652	0.722
D; Education & study	125.32	144.17	150.97	4.678	0.096
Quality of life as a whole	126.42	140.94	158.10	5.044	0.080

6. Differences based on the education level of the parents

An Independent Samples T-test was used to compare families where parents had secondary education or lower versus university education or higher. Table (8) shows no significant differences based on the wife's education level across all dimensions ($P > 0.05$). However, a statistically significant difference ($P = 0.015$) was found in the emotional and psychological dimension (B) based on the husband's education, favoring families where the husband held a university degree or higher.

Table (8): Differences in life scale due to the educational level of the parents

Quality of life scale	Secondary & lower (Mean/SD)	University & higher (Mean/SD)	T-test value	Sign.
Wife's education (n=75 vs n=199)				
A; health & physical	3.51 / 0.547	3.44 / 0.445	1.100	0.272
B; emotional & psych.	3.22 / 1.060	3.36 / 0.937	1.041	0.299
C; Family & social	3.21 / 0.625	3.22 / 0.540	0.017	0.986
D; Education & study	3.14 / 0.893	3.00 / 0.828	1.202	0.231
Quality of Life Scale	3.27 / 0.508	3.25 / 0.448	0.278	0.781
Husband's education (n=103 vs n=171)				
A; health & physical	3.45 / 0.507	3.47 / 0.466	0.554	0.580
B; emotional & psych.*	3.13 / 1.090	3.43 / 0.885	2.440	0.015*
C; Family & social	3.27 / 0.517	3.18 / 0.589	1.341	0.181
D; Education & study	2.98 / 0.864	3.07 / 0.837	0.866	0.387

7. Differences based on the job of parents

The Kruskal-Wallis test results in Table (9) illustrate no statistically significant differences in the overall quality of life or any of its dimensions based on the employment status of either the husband or the wife (all P -values > 0.05). This indicates that the quality of family life was not affected by the employment sector of the parents.

**Table (9): Differences in life scale due to the wife's and husband's work**

Dimension	Government	Private	Self-employed	Retired	None	Sign.
A (Wife)	137.73	125.66	191.40	141.82	135.31	0.56
B (Wife)	140.96	116.97	162.70	124.38	140.92	0.52
C (Wife)	130.80	139.26	142.30	150.64	139.57	0.75
D (Wife)	143.46	105.03	117.80	151.79	133.02	0.22
A (Husband)	141.24	135.11	114.25	141.32	121.75	0.54
B (Husband)	141.75	99.89	155.77	135.02	142.63	0.08



Discussion

The findings of the present study indicate that families experienced a moderate overall level of quality of life during the COVID-19 pandemic. This finding is understandable given the unprecedented nature of the pandemic and the extensive changes it imposed on family life. During the early stages of COVID-19, families were confronted with uncertainty regarding infection, health consequences, education, employment, social interaction, and future economic conditions. In Saudi Arabia, these challenges were accompanied by comprehensive preventive measures, including lockdowns, curfews, restrictions on movement and travel, suspension of face-to-face education, and the transition to distance learning. Although these measures were necessary to contain the spread of the virus, they substantially altered established family routines and affected psychological, social, and behavioral patterns. Algahtani et al. (2021), in a Saudi study conducted during the first wave of COVID-19, reported that the pandemic significantly influenced several dimensions of quality of life and that psychological reactions, particularly depression, anxiety, and stress, were strongly associated with lower quality-of-life scores. These findings provide direct support for the moderate level of quality of life observed in the present study.

The present finding is also broadly consistent with Samlani et al. (2020), who reported that the COVID-19 pandemic and associated quarantine measures negatively affected health and well-being. Their findings indicated that the consequences of prolonged confinement extended beyond infection itself to include physical and psychological aspects of well-being. Similarly, research conducted in Saudi Arabia during the lockdown demonstrated considerable psychological challenges among the population. Alfawaz et al. (2021) found evidence of psychological distress among members of a Saudi university community during the COVID-19 lockdown, highlighting the disruptive psychological consequences of prolonged confinement. Thus, the moderate level of family quality of life found in the present study may be interpreted as the result of a balance between substantial pandemic-related disruption and families' ability to adapt to the new circumstances.

An important aspect of the present findings is that the highest level of quality of life was observed in the health and physical dimension. This result may be attributed to the intensive emphasis on preventive health practices during the pandemic and the widespread dissemination of health information by Saudi health authorities. The Saudi government's early response included extensive public-health campaigns promoting hygiene, social distancing, protective measures, and infection-control practices. Algahtani et al. (2021) similarly demonstrated that physical health was an important component of quality of life during the pandemic in Saudi Arabia. Their findings indicated that individuals with chronic diseases and those experiencing psychological distress were particularly vulnerable to lower quality of life, emphasizing the close relationship between physical and psychological health during the pandemic.



The relatively favorable health and physical dimension may therefore reflect families' increased attention to health protection and their compliance with preventive measures. The pandemic transformed health-related behaviors from individual practices into collective family responsibilities. Families became more attentive to hygiene, infection prevention, health monitoring, and limiting unnecessary exposure to potential sources of infection. In addition, the increased availability of health information may have strengthened individuals' awareness of appropriate protective behaviors. Therefore, the relatively higher health and physical quality-of-life score should not be interpreted as indicating that the pandemic had limited health consequences; rather, it may reflect families' successful adaptation to health-protection requirements.

A particularly noteworthy finding was that families in which the parents were aged 40 years or older reported significantly higher overall quality of life than younger families. This finding may be interpreted in terms of accumulated life experience, psychological adaptation, emotional regulation, and resilience. Although older adults were recognized as a medically vulnerable population during the pandemic, greater physical vulnerability does not necessarily translate into greater psychological vulnerability. Research conducted during the COVID-19 pandemic suggested that older adults may possess psychological resources that enable them to manage stressful situations more effectively.

Finlay et al. (2021), in a qualitative study of older adults during the COVID-19 pandemic, found that older adults employed a range of adaptive coping strategies, including maintaining routines, accepting circumstances, engaging in meaningful activities, and relying on social and emotional resources. The authors emphasized that older adults demonstrated considerable capacity for adaptation despite the uncertainty and restrictions created by the pandemic. These findings provide a plausible explanation for the higher quality of life observed among families with older parents in the present study.

Further support is provided by Sterina et al. (2021), whose systematic review examined emotional resilience, stress, anxiety, depression, and well-being among older adults during quarantine. The review indicated that older adults frequently demonstrated lower levels of negative psychological outcomes than younger adults, despite their greater physical risk from COVID-19. This apparent paradox suggests that chronological age may be accompanied by psychological resources that protect well-being during stressful circumstances.



Age-related emotional regulation may constitute one such resource. Carstensen et al. (2021) reported that age-related differences in emotional well-being remained evident during the COVID-19 pandemic and examined acceptance as a potential mechanism underlying differences in emotional responses between younger and older adults. Accordingly, older parents may have been better able to accept circumstances that could not readily be changed, regulate negative emotional responses, and draw on previous experiences of coping with adversity. The present finding may therefore reflect not simply the effect of age itself but the cumulative effects of experience, emotional maturity, acceptance, and adaptive coping.

This interpretation is also consistent with the finding reported by Al-Aitan et al. (2021), who found that participants aged over 50 years had better quality of life than participants in other age groups. Thus, the convergence between the present findings and previous evidence suggests that older age may represent a psychological resource in the context of large-scale crises, even though older individuals may simultaneously face greater physical health risks.

Another significant finding was the higher emotional and psychological quality of life among families in which the husband had a university education or higher. This relationship may be explained through the potential role of education in enhancing health literacy, information processing, perceived control, and coping ability. During COVID-19, individuals were exposed to rapidly changing and sometimes contradictory information concerning infection, prevention, treatment, and government regulations. Higher educational attainment may have enabled individuals to evaluate information more critically, distinguish reliable information from misinformation, and make more informed decisions concerning family health and safety.

This interpretation is consistent with Al-Aitan et al. (2021), who reported higher quality of life among individuals with higher educational attainment, particularly those with graduate-level education. The present finding may therefore reflect the broader relationship between education and individuals' ability to understand and respond effectively to health-related information.

The role of education may also be particularly relevant to psychological well-being because uncertainty is an important source of stress during a public health crisis. Individuals who perceive themselves as capable of understanding a threatening situation and taking appropriate action may experience greater perceived control and consequently less psychological distress. In the family context, a highly educated husband may also contribute to the dissemination of reliable information within the household, facilitate decision-making, and encourage compliance with preventive measures. These processes may indirectly contribute to greater emotional stability among family members.



However, this explanation should be interpreted cautiously. The present study did not directly measure health literacy, perceived control, or information-seeking behavior. Therefore, these variables should be regarded as possible mechanisms underlying the relationship between husbands' educational attainment and family quality of life rather than as established causal pathways.

In contrast, the absence of statistically significant differences in quality of life according to the wife's educational level is also worthy of consideration. This finding does not necessarily imply that women's education has no influence on family well-being. Rather, the effect of education may be mediated by family roles, household decision-making, communication patterns, and the extent to which educational resources are translated into health-related behaviors. The significant relationship with the husband's education may reflect the specific social and family context of the study population rather than an inherent difference between the educational contributions of husbands and wives. Future studies should therefore investigate whether gender, family roles, health literacy, and decision-making mediate the relationship between education and family quality of life.

The findings further demonstrated that family quality of life did not differ significantly according to parents' employment status. This finding is interesting because employment is generally regarded as an important determinant of economic and psychological well-being. Indeed, Algahtani et al. (2021) found that individuals who lost their jobs during the pandemic were more likely to report lower quality-of-life scores in Saudi Arabia. The difference between that finding and the present result may be explained by differences in the unit of analysis. Algahtani et al. examined individuals' quality of life, whereas the present study focuses on family quality of life. Family-level resources, including emotional support, shared responsibilities, savings, assistance from relatives, and collective coping, may have reduced the effect of individual employment circumstances on overall family quality of life.

The absence of differences according to the number of children may similarly be interpreted within the family-adaptation framework. On the one hand, having more children may increase household responsibilities, educational demands, and financial pressures during lockdown. On the other hand, children may strengthen family interaction and provide opportunities for shared activities and emotional bonding. Consequently, the positive and negative effects of family size may have partially offset each other, resulting in no statistically significant differences in overall quality of life.



Family relationships may have played a particularly important protective role during the pandemic. Alfawaz et al. (2021) reported that family bonding during lockdown was associated with psychological well-being, indicating that strong family relationships may serve as a protective resource against anxiety and depression. This finding is highly relevant to the present study because the family represented one of the primary sources of emotional and social support during periods when contact with the wider community was restricted. Increased time spent at home may have strengthened opportunities for communication, shared activities, mutual support, and collective coping, thereby helping families maintain a relatively stable level of quality of life despite the external crisis.

The absence of significant differences according to monthly family income is another noteworthy result. Under ordinary circumstances, income is an important determinant of quality of life because it influences access to health services, housing, education, leisure, and other resources. However, the COVID-19 pandemic represented a collective stressor that affected families across socioeconomic groups. During periods of lockdown, even families with relatively high incomes experienced restrictions on movement, social interaction, education, and access to normal recreational activities. Consequently, the psychological and social effects of the pandemic may have partially reduced the protective effect normally associated with higher income.

This interpretation should not be taken to mean that socioeconomic status was irrelevant to pandemic experiences. Rather, the finding suggests that during the specific period examined in the present study, the immediate effects of a shared public-health crisis may have been sufficiently pervasive to reduce observable differences between income groups. Algahtani et al. (2021) similarly showed that the pandemic affected environmental and social dimensions of quality of life in Saudi Arabia, with environmental factors explaining a substantial proportion of overall quality-of-life variability.

The absence of significant differences according to region of residence may also be explained by the nationwide nature of the preventive measures implemented in Saudi Arabia. Unlike localized emergencies, COVID-19 generated a common national experience characterized by restrictions on movement, changes in education, social distancing, and concerns about infection. The widespread application of these measures may have reduced regional differences in the factors directly affecting family quality of life. Nevertheless, the absence of statistical significance should not be interpreted as proof that all regions experienced the pandemic identically. Rather, it indicates that regional differences were not sufficiently large to produce statistically detectable differences within the present sample.



The present findings partially differ from those reported by Al-Aitan et al. (2021), particularly with respect to employment status. Such differences are not unexpected because studies conducted during the COVID-19 pandemic varied considerably in sample characteristics, timing, geographical context, measurement instruments, and the specific stage of the pandemic in which data were collected. Moreover, individual-level and family-level measures of quality of life may respond differently to socioeconomic factors. Thus, the discrepancy between the present study and previous research may reflect contextual differences rather than a contradiction in the underlying relationship.

Taken together, the findings indicate that family quality of life during the COVID-19 pandemic was shaped by a complex interaction between pandemic-related stressors and family-level adaptive resources. The moderate overall level of quality of life reflects the substantial disruption associated with the pandemic, while the relatively higher health and physical dimension suggests that families were able to adapt to health-protection requirements. The higher quality of life among families with older parents may be associated with accumulated life experience, emotional regulation, acceptance, and resilience. The higher emotional and psychological quality of life among families in which the husband had higher education may reflect greater access to information, health literacy, perceived control, and adaptive decision-making. At the same time, the absence of significant differences according to employment, family size, income, and region suggests that the collective nature of the pandemic may have attenuated some of the differences that are normally associated with socioeconomic characteristics.

Overall, the present results emphasize the importance of considering the family as an adaptive social system during major public-health crises. Family cohesion, emotional support, effective communication, health knowledge, and adaptive coping may function as protective resources capable of buffering the negative effects of widespread disruption. Consequently, interventions designed to improve family quality of life during future crises should not focus exclusively on economic assistance or individual psychological services. They should also strengthen family communication, health literacy, coping skills, and access to reliable health information. Such an integrated family-centered approach may enhance resilience and contribute to maintaining quality of life when families are exposed to prolonged and collective crises.

Recommendations and Suggestions

Based on the findings, the study recommends the following to improve family quality of life, particularly focusing on the educational and psychological aspects which were notably affected during the pandemic:

1. **Community Interventions:** There is a strong need for community-based interventions designed to mitigate the social effects of the epidemic and to strengthen family and social relations.



2. **Psychological Awareness Programs:** Implementation of psychological awareness programs is crucial to mitigate the emotional effects of crises. Such recommendations align with the Kingdom's Vision 2030, which focuses on meeting individuals' needs to live a healthy life and providing preventive measures against psychological distress.
3. **Future Research on Broader Demographics:** Conducting further studies on a larger, more diverse sample of the community, including males and females, to compare quality of life levels more comprehensively.
4. **Focus on Vulnerable Groups:** Conducting targeted studies on individuals with chronic diseases to reveal their specific quality of life challenges during public health emergencies.

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Volume (82) August 2022

العدد (82) أغسطس 2022



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