

ORIGINAL ARTICLE OPEN ACCESS

Behind the Mask: Recognising the Person in Relatives of Nursing Home Residents—A Qualitative Meta-Synthesis

Rouven Brenner^{1,2}  | Theresa Clement^{1,3}  | Julian Hirt^{2,4,5}  | Hanna Mayer³  | Heidrun Gattinger² 

¹Department of Nursing Science, University of Vienna, Vienna, Austria | ²Eastern Switzerland University of Applied Sciences, School of Health Sciences, Institute of Health Sciences, St. Gallen, Switzerland | ³Department of Nursing Science, Karl Landsteiner University of Health Sciences, Krems, Austria | ⁴Pragmatic Evidence Lab, Research Centre for Clinical Neuroimmunology and Neuroscience Basel, University Hospital Basel and University of Basel, Basel, Switzerland | ⁵Institute of Health and Nursing Science, Medical Faculty, Martin Luther University Halle-Wittenberg, Halle (Saale), Germany

Correspondence: Rouven Brenner (a12250314@unet.univie.ac.at)

Received: 17 November 2025 | **Revised:** 17 November 2025 | **Accepted:** 27 May 2026

Keywords: institutional long-term care | meta synthesis | person-centred care | personhood | relatives

ABSTRACT

Background: Relatives of nursing home residents are deeply involved in care relationships that extend far beyond visiting routines. However, their broader personhood is often overlooked, with existing research focusing on functional roles. This meta-synthesis aims to explore how relatives experience “being relative” within institutional long-term care, highlighting the complexity of their identity beyond institutional expectations.

Methods: We conducted a qualitative meta-synthesis of 59 peer-reviewed studies using Thomas and Harden’s thematic synthesis approach. We systematically searched four databases (MEDLINE, CINAHL, Emcare, and PsycInfo) from inception to 17. In January 2024 and conducted citation tracking. Grounded in a social constructionist perspective, we conceptualised “being relative” as a relational identity co-constructed through everyday interactions with staff in an institutional context.

Results: Four interconnected themes characterise relatives: (i) Managing Ambiguity (navigating emotional complexity between gratitude and criticism), (ii) Fluid and Overlapping Roles (continuously shifting between advocacy, observation, and mediation), (iii) Dynamic Relationship Development (evolving connections with staff through recognition and challenge cycles), and (iv) Negotiating Care Responsibility (ongoing adaptation of involvement patterns). These themes form a cyclical model illustrating how relatives continuously navigate between institutional expectations and authentic experiences. Rather than inhabiting static roles, relatives engage in dynamic positioning processes, constantly adapting and reinterpreting their place within care settings.

Conclusions: “Being relative” represents a dynamic process of continuous adaptation and meaning-making within institutional constraints, extending beyond functional role assignments. Our cyclical model challenges reductionist approaches and emphasises the need for person-centred care that recognises relatives as whole persons with complex identities and emotional needs. By acknowledging the person behind the institutional “mask,” care facilities can improve relatives’ experiences, enhance care quality for residents, and increase staff satisfaction—demonstrating the potential of truly person-centred approaches in long-term care.

1 | Background

Relatives of nursing home residents engage in multifaceted relationships extending far beyond visiting. They actively maintain emotional continuity, offer crucial support, and collaborate in

care processes while being in and shaping relationships with residents and staff [1–3]. This dynamic involvement can positively impact residents’ quality of life, increase staff job satisfaction, and enhance the psychological well-being of relatives [4, 5]. Yet, despite these significant contributions, the self-conception and

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2026 The Author(s). *Scandinavian Journal of Caring Sciences* published by John Wiley & Sons Ltd on behalf of Nordic College of Caring Science.

external perception of being a relative in institutional care remain insufficiently theorised and conceptually underdeveloped.

In nursing homes, relatives navigate a triadic relationship involving residents, professional caregivers, and themselves [2, 6]. This triangular interaction often generates conflicts between needs, expectations, and interests, resulting in ambiguity and emotional tension. Staff frequently understand relatives primarily through their functional roles, whilst relatives report feeling excluded or disempowered in these encounters [7, 8]. However, when effectively navigated, such relationships foster mutual understanding, emotional support, and shared responsibility, highlighting the relational and co-constructed nature of “being relative” [2].

1.1 | “Being Relative”

The concept of “being relative” invites us to look beyond institutional labels, shifting our perspective to the relative as a person. When discussing “being” a person, we refer to McCormack & McCance’s conception, which they term “modes of being” but which we conceptually and linguistically prefer to describe as “states of being” (drawing on the German concept of “Seinszustände”), the ontological underpinning of their approach to person-centred nursing, care and practice. These “states of being” emphasise the importance of understanding “being” as in relationship to oneself, others, place, time, and social context [9]. Within this framework, “being relative” represents a kinship status and a lived, meaningful connection with someone in long-term care [9]. This connection manifests through relatives’ everyday practices, emotional investments, and co-created meanings as an ongoing, dynamic process of being and becoming [10]. “Being relative” offers a powerful starting point for reconceptualising the understanding of relatives in institutional long-term care.

The complexity of “being relative” stems partly from their simultaneous positioning as residents’ advocates whilst managing their emotional and practical needs. This dual positioning creates persistent ambiguity and generates partly contradictory emotional responses, such as relief and guilt, particularly in the institutional context [11, 12]. Relatives navigate an ever-changing terrain shaped by fluctuating, often conflicting feelings and expectations that require constant negotiation [13].

We understand “being relative” as a relationally co-constructed identity emerging through intersubjective processes with residents, staff, and institutional settings. Grounded in social constructionist theories [14, 15], this research examines relatives’ experiences, focusing on self-conceptions and external perceptions in dyadic encounters with professional caregivers.

1.2 | “Behind the Mask”

Previous research has predominantly framed relatives through narrow functional lenses—as visitors, caregivers, information providers, or decision-makers [16, 17]. These designations risk depersonalisation by overlooking the broader identity and personhood of relatives. Understanding relatives as persons,

focusing on their personhood rather than these roles, offers an alternative perspective. The term “person”, etymologically linked to “persona” (the theatrical mask), inherently contains ambiguity between outward presentation and internal experience [18]. The ambiguity is particularly relevant for relatives, who frequently balance visible contributions to the care environment with invisible emotional labour. Goffman’s idea of life as a stage provides an apt and explanatory metaphor: People wear different “masks” depending on context [15]. In nursing homes, relatives often adopt institutional “masks”—appearing as visitors, advocates, or carers—whilst their identities, emotional experiences, and subjective meanings remain concealed behind these performed positions. The tension between these externally imposed roles and relatives’ authentic experiences creates ongoing internal struggles [18, 19]. By looking beyond institutional roles to recognise the personhood of relatives behind the mask, we can develop more person-centred approaches that enhance long-term care experience for residents, relatives and staff alike.

1.3 | Need for Care That Focuses on Relatives—Person-Centred

Existing person-centred care models have primarily focused on residents and occasionally staff, leaving relatives underconsidered as individuals in their own right [20, 21]. Whilst person-centred approaches typically focus on residents as whole individuals with histories and preferences [22, 23], the same recognition should extend to relatives. Despite their essential influence in shaping the care context, institutions often sideline relatives’ voices, perspectives, and contributions. Additionally, “being a relative” encompasses a wide range of people with diverse cultural backgrounds, emotional ties, and family structures—each shaping their experience and involvement in unique ways that standard care models rarely acknowledge [24].

While qualitative reviews have explored aspects of family involvement [7, 11], they primarily focus on functional contributions, leaving relational, emotional, and identity dimensions underexplored. Despite acknowledged importance, no comprehensive framework captures how relatives experience ‘being a relative’ beyond institutional roles, representing a significant conceptual gap. This gap has practical implications for person-centred care models that fail to sufficiently acknowledge relatives as whole persons with complex identities and emotional needs.

A qualitative meta-synthesis offers a suitable methodological approach to address this gap, facilitating the systematic integration and reinterpretation of existing qualitative findings to generate new theoretical insights. This qualitative meta-synthesis examines how relatives understand and experience their ‘being relative’ beyond institutional functions and how nursing staff perceive them. Grounded in social constructionist principles, we systematically integrate qualitative findings from studies to develop a conceptual model that explicates the dynamic, relational processes through which relatives manage their position within institutional long-term care. By looking beyond formal roles and responsibilities and taking a glimpse behind the mask of institutional expectations, we seek to develop a more nuanced, person-centred understanding of relatives as individuals navigating the complex realities of institutional long-term care.

2 | Methods

We conducted a qualitative meta-synthesis using Thomas and Harden's thematic synthesis approach [25]. We examined this phenomenon beyond fixed roles as relationally co-constructed identities. Our social constructionist epistemology [14, 15], which views identity as emergent through interaction rather than fixed, directly informed our methodological approach. This method enables us to examine how relatives' identities are co-constructed through interactions while maintaining methodological transparency through the systematic documentation of our analytical process.

2.1 | Methodological Approach and Rationale

We employed Thomas and Harden's thematic synthesis approach [25], which provides a systematic method for identifying and developing analytical themes across qualitative studies. This three-phase approach enables us to move beyond descriptive categorisation to generate conceptual insights through interpretative analysis. Following Sandelowski and Barroso's [26] conceptualisation, we approach meta-synthesis as a transformative analytical process aimed at conceptual expansion, enabling us to explore how relatives experience and make meaning of their position "behind the mask" of institutional roles.

To ensure methodological rigour and analytical transparency, we applied reflexive principles from Braun and Clarke [27] throughout our synthesis process. Specifically, we maintained reflexive memos documenting analytical decisions, regularly discussed emerging interpretations within the research team to examine different perspectives, and critically examined how our social constructionist theoretical framework shaped the approach to theme development [27, 28] throughout our synthesis process. This approach enhanced our ability to examine how relatives' identities are co-constructed through interactions while maintaining systematic documentation of our analytical decisions and interpretative reasoning. This reflexive approach acknowledges the researcher's active role in interpretation whilst utilising Thomas and Harden's progressive synthesis structure.

We structure our manuscript based on the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement [29]. We deliberately chose not to conduct a formal quality assessment, prioritising conceptual breadth and depth over methodological hierarchy, as rigid quality standards might exclude studies with valuable conceptual contributions when exploring lived experiences [25, 26].

2.2 | Eligibility Criteria, Information Sources, Search Strategy, and Study Selection

We included per-reviewed studies with qualitative or mixed-methods designs published in English or German that explored experiences, perceptions, and attributions related to relatives of individuals living in 24-h institutional long-term care. Consistent with our conceptual framework, we included data from relatives and those capturing staff perspectives on relatives, allowing for an examination of the interplay between self-conception and external perception.

We excluded studies focused on other care settings, populations with physical or intellectual disabilities, exceptional situations (e.g., end-of-life, transitions, pandemics), interventional designs, or non-empirical publications to focus on the everyday experience in typical institutional long-term care contexts.

We searched MEDLINE/PubMed, CINAHL, Emcare/Ovid, and PsycInfo/Ovid from inception to 17. In January 2024, using index terms and keywords related to 'relatives', "roles and perceptions", 'and' institutional long-term care. The search strategy was developed collaboratively by two authors, following the PRESS 2015 guidelines for per review of electronic search strategies, ensuring transparency and methodological rigour [30]. We provide the entire electronic search strategy, including all database-specific search strings and search details, in the [Supporting Information](#) (see Additional file 1, Search strategy and documentation). In addition, we performed forward and backward citation searching via Scopus (one iteration) using all database-retrieved study reports as seed references [31].

2.3 | Data Extraction and Management

Following initial discussions by two reviewers, one reviewer extracted bibliographic data, study features, and relevant findings using MAXQDA 24. We defined relevant findings as all content in the Results sections addressing relatives' experiences, staff perceptions of relatives, or relational dynamics between relatives and staff, emphasising both primary data (participant quotes) and authors' interpretations to engage with participants' voices and researchers' insights.

2.4 | Three-Phase Thematic Synthesis Process

2.4.1 | Phase 1: Line-By-Line Coding

We began with intensive familiarisation, systematically reviewing study findings to identify key patterns in relatives' emotional experiences and the tensions between professional and familial perspectives. We noted that role assignments vary from active participation to passive observation and that institutional contexts influence relatives' experiences.

We developed 157 initial codes through line-by-line coding of all extracted findings. Through iterative comparison and team discussion, we consolidated these into 82 codes by merging conceptually overlapping codes (e.g., 'feeling excluded' and 'feeling marginalised'), refining code boundaries, and eliminating redundancies to increase analytical clarity. Using these codes, we generated two visual code matrices to explore dimensional relationships:

Matrix 1 ('Emotional Experience of Relatives') positioned codes along two dimensions: Emotional valence (negative, ambivalent, and positive) and effect on staff-relative relationships (destructive and constructive).

Matrix 2 ("Perception of Relatives") mapped codes by relatives' engagement level (passive-active) and nursing staff perceptions (burden-resource).

Codes were positioned through iterative team discussion, examining how they manifested across studies. These visual mappings revealed clustering patterns (e.g., active engagement sometimes perceived as ‘demanding’ vs. ‘partnering’) and informed theme development by showing how emotional experiences and role perceptions interconnected.

2.4.2 | Phase 2: Development of Descriptive Themes

We refined our consolidated codes and early thematic structures through iterative comparison across studies, identifying patterns transcending individual contexts while remaining sensitive to situational nuances.

Our descriptive themes emerged around four key domains [1]: emotional landscape of relatives’ experiences, including ambiguity, uncertainty, and vigilance [2]; negotiation of roles and responsibilities [3]; institutional structures enabling or constraining relatives’ agency; and [4] relational dynamics that shape relatives’ sense of belonging. While valuable, these descriptive themes primarily remained at the level of categorisation rather than conceptual integration.

2.4.3 | Phase 3: Generation of Analytical Themes

We defined four overarching analytical themes through a recursive process that involved moving between the descriptive

themes, the original data, and our social constructivist theoretical framework. This process identified conceptual threads connecting seemingly disparate aspects of relatives’ experiences, such as underlying identity construction processes linking emotional ambiguity and role negotiation.

The interrelations among these themes formed what we conceptualised as a dynamic and cyclical pattern of positioning, where emotional ambiguity, role fluidity, relational development, and negotiated responsibility influenced each other over time. This interplay illustrates that relatives continually adapt, reposition, and reinterpret their roles in care processes rather than occupying static roles.

3 | Results

Two reviewers independently screened 3598 titles and abstracts after removing duplicates, followed by 605 full-text reviews, resulting in 59 included studies that followed the PRISMA guidelines [32] (Figure 1).

The 59 included studies represented diverse geographical contexts from 14 countries, with participants primarily being daughters (47 studies), sons (42), and spouses (40). Data collection primarily consisted of semi-structured interviews ($n = 38$), focus groups ($n = 12$), and ethnographic observations ($n = 8$). We provide an overview of the included studies in the [Supporting Information](#) (see Additional file 2, Description of included studies).

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources

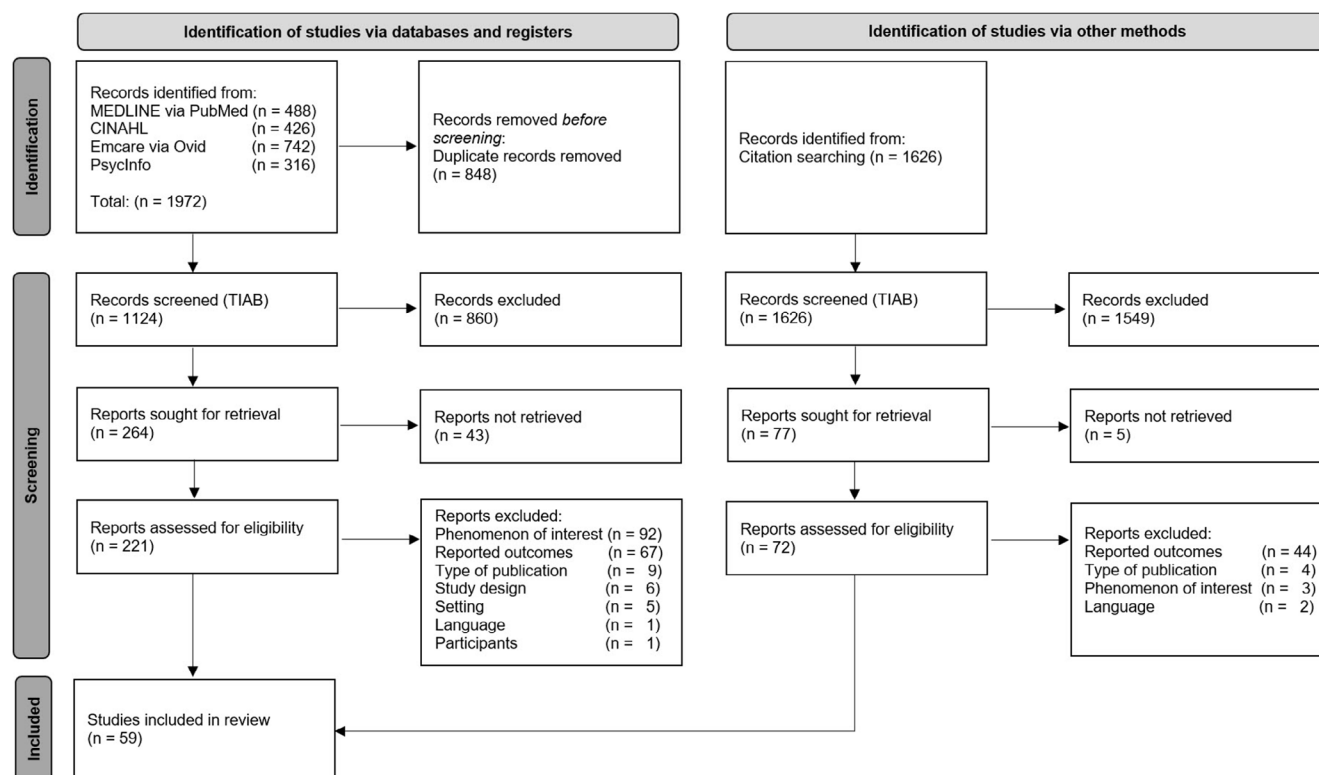


FIGURE 1 | PRISMA flow diagram. The flow diagram shows the study identification and selection process for the qualitative meta-synthesis. We identified 3598 records through database searches after removing duplicates. Following title and abstract screening and full-text review, we included 59 studies in the final analysis.

Our systematic extraction of primary quotes and author interpretations enabled the identification of patterns while remaining grounded in lived experiences. Our qualitative meta-synthesis identified four interconnected themes that capture how relatives experience and navigate their position within institutional long-term care settings: (i) managing ambiguity, (ii) fluid and overlapping roles, (iii) dynamic relationship development, and (iv) negotiating care responsibilities.

Rather than discrete categories, these themes function as dynamic elements in a continuous cycle of experience (Figure 2). Our analysis reveals what exists behind institutional roles—a complex emotional landscape characterised by ambiguity, fluid positioning, and continuous adaptation.

3.1 | Managing Ambiguity: Between Gratitude and Criticism

Relatives described experiencing a persistent state of emotional ambivalence within institutional care. Rather than experiencing a single, dominant emotional response, they reported coexisting and often conflicting emotions, such as gratitude and frustration, trust and suspicion, or relief and guilt. This theme comprises three interconnected subthemes that illustrate how relatives moved between appreciation, doubt, vulnerability, and acceptance.

3.1.1 | Balancing Contradictory Emotions

Relatives frequently expressed mixed emotional responses, appreciating staff efforts while simultaneously questioning whether their relative's individual needs were recognised. The following quote illustrates this ambivalence by juxtaposing gratitude with concern:

“I am grateful for the basic care they provide, really I am... but sometimes I wonder if anyone is really listening when I mention her preference for showering in the evenings rather than mornings.”

[33]

Such expressions reflect a deliberate attempt to advocate for personalised care while avoiding the impression of being overly critical. This emotional duality was evident in codes such as “feeling ambivalent”, “feeling trustful” and “feeling suspicious”.

3.1.2 | Experiencing Vulnerability

Relatives also described feeling marginalised or powerless within institutional structures, notably when excluded from decision-making or meaningful conversations. Beyond indicating a structural imbalance, the quote below conveys the emotional impact of being positioned as an outsider:

“Being perceived as ‘the Other’... gave relatives a feeling of powerlessness and alienation.”

[34]

These experiences were reflected in codes such as “feeling marginalised”, “feeling disempowered” and “feeling excluded”.

3.1.3 | Finding Acceptance and Appreciation

Despite structural constraints, many relatives actively reframed their experiences by emphasising moments of welcome, recognition or partnership. These interactions helped them re-establish a sense of connection and reduced the emotional burden associated with institutional care:

“Relatives who felt welcome and ‘at home’ seemed to see their role as in partnership with staff.”

[35]

These positive encounters often alternated with more difficult experiences, underscoring the inherently ambivalent nature of relatives' emotional trajectories. This pattern of coexisting emotions influenced how relatives engaged with care processes and is directly linked to the following theme on role fluidity.

Across studies, these experiences did not occur in isolation. However, they shifted over time, creating a pattern of emotional uncertainty in which relatives could not reliably anticipate how interactions with staff, organisational routines or care events would unfold. This broader sense of uncertainty aligns with our overarching theme of ambiguity, which captures not only the coexistence of opposing emotions (ambivalence) but also the fluctuating and unpredictable nature of emotional responses in institutional care. Figure 2 illustrates how this emotional ambiguity shaped relatives' engagement in care roles and connects directly to the next theme on role fluidity.

3.2 | Fluid and Overlapping Roles

Relatives did not occupy fixed positions in the care environment but moved between multiple, overlapping roles that shifted in response to residents' needs, staff practices, and organisational constraints. Across studies, this fluidity reflected both pragmatic adaptation and the ambivalent expectations relatives held about their responsibilities. Three interrelated subthemes illustrate how these roles were enacted.

3.2.1 | Active Advocacy and Care Provision

Relatives often took on roles that extended beyond traditional family responsibilities. They monitored the quality of care, intervened when they perceived unmet needs, and sought to protect residents from perceived risks. These actions were often motivated by a strong sense of responsibility and vigilance. One study described this protective stance succinctly:

“Family caregivers' prime concern now was checking on the quality of care.”

[36]

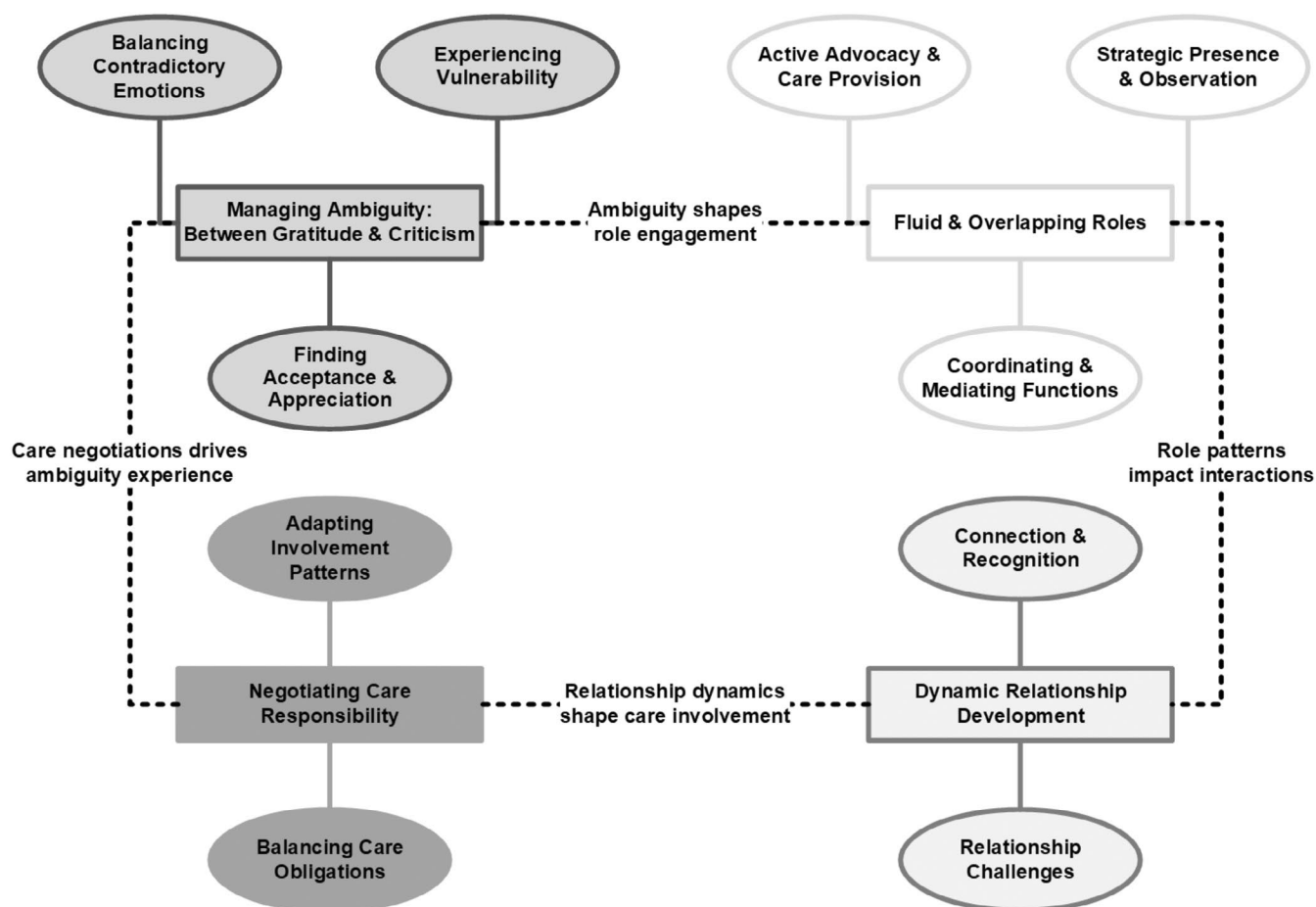


FIGURE 2 | “Being relative” in institutional long-term care—a cyclical model. The model illustrates four interconnected themes (rectangles) and their subthemes (ovals): Managing Ambiguity, Fluid and Overlapping Roles, Dynamic Relationship Development, and Negotiating Care Responsibility. Shaded shapes indicate dimensions with strong emotional valence, while unshaded shapes represent dimensions that are primarily structural or relational. The dotted lines represent cyclical, reciprocal relationships where each theme influences the next in an ongoing adaptive process. The cycle can begin at any point, depending on the relative’s entry into or triggering event within the care setting, and proceeds through continuous mutual influence between emotional experiences, role engagement, relationship dynamics, and responsibility negotiation.

Such engagement was reflected in codes including “being an advocate,” “being a quality controller,” and “being a direct carer.” While these actions supported residents’ well-being, they sometimes created friction when staff interpreted them as intrusive or boundary crossing.

3.2.2 | Strategic Presence and Observation

Relatives also adjusted their involvement according to staff receptiveness and situational demands. They maintained a form of strategic presence—being “on hand” without appearing overbearing—and closely observed routines to identify whether adjustments were needed. One synthesis highlighted this pattern:

“They continually observed what was happening in the facility and how staff went about their work.”

[33]

This behaviour aligns with codes such as “being a visitor” and “being an observer”, revealing how relatives balanced attentiveness with caution to preserve constructive relationships with staff.

3.2.3 | Coordinating and Mediating Functions

Relatives facilitate communication between various parties. According to multiple studies, they often served as informal intermediaries, translating care practices and resolving misunderstandings. This behaviour was evident in codes related to “being a guardian”, “being an information provider”, and “being a teambuilder”.

At the same time, relatives expressed ambivalence about how assertive they should be in these mediating roles. While they recognised the importance of advocating for their family members, they were cautious about jeopardising their relationships with staff. This tension was described in one study as:

“Fear and ambivalence about rocking the boat. Although participants recognised the importance of advocating, they expressed reservations about approaching care staff.”

[37]

These overlapping roles and the ambivalence surrounding them influenced how relatives engaged with staff. In our conceptual model, they form a direct bridge to the subsequent theme on relationship development.

3.3 | Dynamic Relationship Development

Relationships between relatives and staff evolved and shifted in response to everyday interactions, organisational routines and individual expectations. Across studies, these relational dynamics were shaped by moments of recognition and connection as well as by experiences of disappointment, exclusion and rupture. Two contrasting subthemes captured this development.

3.3.1 | Connection and Recognition

Relatives reported positive responses when staff acknowledged their role, involved them in discussions or expressed appreciation for their contributions. These interactions created a sense of reciprocity and mutual understanding. One study described this dynamic as follows:

“The contribution by families (...) was clearly acknowledged by staff and management.”

[38]

These experiences aligned with codes such as “feeling connected” and “feeling informed,” as well as institutional views of “relatives as partners.”

3.3.2 | Relationship Challenges

Conversely, relatives felt dismissed, excluded, or positioned as outsiders. These experiences were particularly common when relatives voiced concerns or requested changes to care practices. One study illustrated this pattern:

“Although most participants believed that they had developed good relationships with staff members, participants also recognised that their ability to be vigilant was impeded by the care staff’s view that close family members were, ultimately, outsiders.”

[37]

Such dynamics frequently led to emotional distancing or withdrawal, reflected in codes related to “feeling marginalised” and “feeling powerless”.

Across these contrasting experiences, relatives described a sense of ambiguity in their relational position. They sometimes felt valued and included, yet at other times perceived themselves as unwelcome or peripheral. These shifts—trust in individual carers coupled with scepticism towards institutional processes—directly influenced how relatives approached their caregiving responsibilities. This connection forms a bridge to the following theme.

3.4 | Negotiating Care Responsibility

This theme revealed that relatives’ caregiving involvement was neither fixed nor uniformly defined, but instead shifted over time in response to their own capacities, the residents’ needs, and institutional demands. Relatives continuously evaluated how much they should contribute, when they should step back and what level of involvement felt sustainable. Two subthemes capture this negotiation process.

3.4.1 | Balancing Care Obligations

Relatives sought to reconcile moral commitments with the practical and emotional limits imposed by long-term care settings. Many experienced dilemmas when trying to determine an appropriate level of involvement. Studies reported feelings of guilt when they perceived their engagement as insufficient and frustration when demands felt excessive. These tensions were reflected in codes such as “feeling responsible” and “feeling (not) guilty.” One study illustrated this emotional burden:

“They suffered from guilt if they felt that they had not visited them often enough.”

[34]

Relatives described this balancing process as ongoing and shaped by expectations from staff, residents and their own sense of duty.

3.4.2 | Adapting Involvement Patterns

Relatives adjusted their engagement over time in response to relational experiences, institutional routines and changes in residents’ conditions. Some increased their involvement when trust in staff was low or when care needs intensified; others reduced their presence when relationships with staff deteriorated, or personal strain became overwhelming. These adaptations appeared in codes such as “being a delegator,” “being a practical supporter”, “being a family caregiver”, and “being a direct carer”. One study highlighted this variation:

“Family involvement in the lives and care of residents was noted by staff to vary greatly; some families were perceived to have a strong allegiance with the facility and visit frequently, whereas others did not want to be involved at all.”

[33]

These shifting involvement patterns demonstrate how relatives negotiated responsibility within the constraints of both structural and relational factors. This negotiation shaped later experiences of emotional burden and connects directly to the subsequent theme on relational dynamics across the model.

3.5 | Relational Dynamics Between Themes

Our analysis revealed strong reciprocal links between themes, forming a cyclical model of relatives' experiences (Figure 2). Emotional ambiguity shapes how relatives assume roles, with ambiguous feelings influencing the intensity and type of role engagement. Role performance, in turn, influences relationship quality, as advocacy roles sometimes create tensions while mediating roles foster positive connections.

Relationship quality subsequently affects how relatives assume responsibility, with positive relationships enabling greater involvement and conflictual relationships often leading to withdrawal. Finally, relatives experience different emotions depending on their assumed level of responsibility: High responsibility can intensify ambiguity, while clear boundaries can reduce the emotional burden.

Our synthesis reveals a dynamic interplay between these themes across studies despite varying contexts and methodologies. It demonstrates that the experience of "being relative" in institutional long-term care extends beyond static role categorisations to encompass a complex, dynamic process of continuous adaptation and meaning-making within institutional constraints. Rather than merely performing predefined functions, relatives actively navigate, interpret, and reshape their identities through ongoing interactions with residents, staff, and care systems.

The synthesis findings go beyond aggregating findings to offer a conceptual model that captures the dynamic and relational nature of relatives' experiences. By examining self-conception and external perception, our analysis reveals the complex processes through which relatives continuously negotiate their place within institutional care settings.

4 | Discussion

This qualitative meta-synthesis investigated how relatives of nursing home residents experience "being relative" and how staff perceive them within institutional long-term care settings. Our analysis of 59 qualitative studies identified four interconnected themes that characterise relatives' experiences: Managing Ambiguity, Fluid and Overlapping Roles, Dynamic Relationship Development, and Negotiating Care Responsibility. Together, these themes form a cyclical model that illustrates how relatives continuously navigate between institutional expectations (the "mask") and their authentic experiences. This model demonstrates that "being relative" extends beyond institutional roles and represents a complex, dynamic process of continuous adaptation and meaning-making within institutional constraints.

Our findings illustrate how relatives construct identity through situated interactions, engaging in dynamic "being relative" processes rather than occupying fixed positions—a lived, evolving identity co-created through everyday practices.

Our findings confirm earlier insights into the emotional complexity that relatives experience in institutional long-term care. The emotional ambiguity we identified resonates with Barken and Lowndes' [11] observations about relatives' mixed feelings and Ryan and McKenna's [13] description of contradictory emotional responses. However, while these studies primarily focused on isolated aspects, our meta-synthesis demonstrates how this emotional ambiguity systematically links to role performance, relationship development, and assumption of responsibility.

The fluidity and overlap of roles we identified extend previous classifications by Davies and Nolan [17] and Baumbusch and Phinney [16]. Whilst these studies categorised relatives into discrete functions such as visitors, caregivers, or information providers, our analysis shows that relatives continuously shift between these positions and embody them simultaneously—a dynamic process that previous research has underconceptualised.

Dupuis and Norris' [10] "Diversity of Experiences Model" provided a significant theoretical framework for understanding the roles of family members in long-term care settings. Their work emphasised that relatives' roles cannot be differentiated merely by tasks performed but encompass meaning, behaviour, and integrally linked expectations. Our findings support and extend this perspective by demonstrating how these roles evolve through ongoing negotiations within institutional contexts. Their focus on role-making processes shaped by social interactions aligns with our theme of Dynamic Relationship Development, where we found that relatives actively construct their identities through interactions with staff, other relatives, and residents.

Dupuis and Norris [10] highlighted the environmental context as crucial in our findings regarding institutional constraints. We extend their work by identifying specific mechanisms for relatives navigating these constraints, particularly through Negotiating Care Responsibility. While Dupuis and Norris established a theoretical framework, our study provides empirical evidence across diverse care settings that validates and enhances their conceptual approach. It offers a more nuanced understanding of how relatives experience their position within care institutions.

Our conceptual contribution is identifying the cyclical, relational character of "being relative". Unlike previous research that primarily defined relatives through their functions, our model shows how self-perception and external positioning interweave in an ongoing, intersubjective process. This perspective resonates with "states of being" (grounded in McCormack and McCance's theory [9]) and Goffman's [15] theory of self-presentation, but extends them through specific application to the context of institutional long-term care.

Our conceptualisation of the "mask" as a metaphor for the tension between institutional role expectations and relatives'

authentic experiences offers a novel theoretical contribution to understanding family dynamics in care settings. This metaphor extends beyond the existing literature on role strain by illuminating how relatives actively construct and reconstruct their identities within institutional constraints rather than simply adapting to predefined roles. Whilst previous studies, such as Holmgren et al. [34], have described relatives' positioning as "betweenship", our model offers a more comprehensive conceptualisation that explains how relatives actively negotiate this position.

4.1 | Strengths and Limitations

A central strength of our study lies in the broad geographical and temporal span of included studies (59 studies from 14 countries, published between 1988 and 2024), which enabled identification of robust, cross-contextual patterns while remaining sensitive to situational nuances. The systematic extraction of primary quotes and author interpretations allowed us to engage with both participants' direct voices and original researchers' analytical insights.

Our study has several methodological considerations worth noting. We decided not to conduct a formal quality assessment of included studies based on epistemological and methodological grounds. While this approach prioritised conceptual breadth and depth, it may have included studies with varying methodological rigour. To address this, we carefully examined methodological descriptions in all included studies. We ensured that our themes were supported by multiple high-quality sources across different research contexts, strengthening the credibility of our findings despite this methodological choice.

The heterogeneity of included studies regarding methodological approaches, contexts, and participant groups represents a methodological strength rather than a limitation. Our reflexive analytical approach transformed this diversity into an asset by enabling the identification of patterns that persist across varied care settings, cultures, and time periods, thereby enhancing the transferability and applicability of our findings to diverse long-term care contexts. This robustness across heterogeneous sources strengthens confidence in the conceptual model.

4.2 | Implications

4.2.1 | Theoretical Implications

Our findings give empirical expression to the ontological orientation proposed by McCormack and McCance, who describe "modes of being" as foundational to person-centred care. In our conceptualisation, we translate these as "states of being", drawing on the German term *Seinszustände*, emphasising their fluid, relational, and situated nature. Relatives actively position themselves to others, time, place, and institutional contexts—not as fixed actors but through ongoing shifts in how they feel, act, and engage. This dynamic pattern reflects the lived complexity of "being relative" as a situated form of personhood, co-created

through practice and context rather than defined solely by institutional roles or kinship.

Our cyclical "being relative" model contributes to theoretical development in understanding relatives in institutional long-term care. It shifts focus from functional role assignments towards a relational understanding of identity as a continuous, co-constructed process. This conceptual shift carries far-reaching implications for theory development in person-centred care, which has traditionally focused primarily on residents and occasionally on staff.

The qualitative meta-synthesis emphasises the need to extend person- and relationship-centred approaches to recognise relatives as whole persons with their own needs, identities, and emotional landscapes. It suggests a need to reconsider person-centredness in long-term care to systematically account for the triadic relationships between residents, staff, and relatives.

The "mask" analogy, based on Goffman's metaphor, offers a theoretical lens for understanding how relatives navigate institutional expectations while maintaining authentic selfhood. This perspective could inform broader theoretical developments in understanding identity maintenance within institutional contexts, extending beyond long-term care to other settings where individuals must balance personal and systemic demands.

4.2.2 | Practice Implications

Our findings suggest several practice implications addressing our identified themes: Acknowledging Ambiguity: Institutions could recognise relatives' emotional ambiguity through reflective dialogue spaces where relatives can express contradictory feelings without judgement, rather than expecting binary satisfaction measures.

Supporting Role Fluidity: Care facilities could establish flexible structures with regular assessments of involvement patterns and adaptive documentation, thereby avoiding rigid role assignments and enabling contextual adaptations.

Fostering Relationship Continuity: Care settings could implement designated contact persons, opportunities for relationship reflection, and conflict resolution protocols that acknowledge the relational history.

Negotiating Responsibility Collaboratively: Facilities could develop explicit processes for discussing care contributions through structured conversations, regular reviews, and flexible adjustment opportunities, recognising responsibility as a dynamic process requiring ongoing negotiation.

4.2.3 | Research Implications

Our findings point to important directions for future research. Future research could integrate our tested cyclical model with existing theoretical frameworks from identity theory, relational ethics, and organisational psychology to enrich the

understanding of the interplay between personal identity and institutional context, thereby strengthening the conceptual foundations for relatives' experiences in long-term care settings.

Given the global scope of our included studies, cross-cultural research could explicitly compare how our cyclical model manifests in different cultural, regulatory, and organisational contexts, distinguishing universal aspects of "being relative" from contextually specific manifestations.

Future research could also develop assessment instruments that capture the dynamic, relational aspects of "being relative" rather than static role classifications, providing more nuanced measures for evaluating support interventions.

5 | Conclusions

Our qualitative meta-synthesis offers a new conceptual understanding of "being relative" in institutional long-term care as a dynamic, cyclical process characterised by emotional ambiguity, fluid roles, dynamic relationship development, and continuous negotiation of responsibility. This understanding challenges us to move beyond reductionist role assignments and recognise relatives as whole persons whose identities undergo relational co-construction.

Our synthesis extends the existing recognition that institutional roles can obscure fuller personhood (Goffman [15]) by providing an empirically grounded, dynamic model that explicates how this tension manifests in relatives' day-to-day experiences and shapes their ongoing positioning within care settings. This contribution advances theoretical understanding by moving beyond general recognition to elucidate the specific mechanisms and processes involved explicitly. Truly person-centred care must recognise and support relatives in their entirety, not just in their functional contributions to the care environment.

By acknowledging and supporting the complex, dynamic process of "being relative", care facilities may be better positioned to improve relatives' experiences, enhance care quality for residents, and support staff in their relational work. Our model contributes to person-centred care frameworks by extending their focus beyond residents to encompass relatives as whole persons within the care triad. Given existing evidence that person-centred approaches enhance experiences and outcomes for residents and staff [39–41], our conceptual model provides a foundation for understanding how such approaches might similarly benefit relatives when their full personhood is recognised and supported within institutional settings.

Author Contributions

R.B. Conceptualisation, Methodology, Literature search, Data extraction, Data analysis, Writing – original draft, Writing – review and editing. T.C. Conceptualisation, Methodology, Data analysis, Writing – review and editing, Supervision. J.H. Methodology, Data analysis, Writing – review and editing, Supervision. H.M. Conceptualisation, Writing – review and editing, Supervision. H.G. Conceptualisation, Methodology, Data analysis, Writing – review and editing, Supervision, Project administration. All authors have read and approved the final.

Acknowledgements

Open Access funding provided by Universitat Wien.

Funding

The University of Vienna provided open-access funding.

Ethics Statement

The authors have nothing to report.

Consent

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

References

1. S. Davies and M. Nolan, "‘Making the Move’: Relatives' Experiences of the Transition to a Care Home," *Health & Social Care in the Community* 12, no. 6 (2004): 517–526 Available from, <https://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=106676787&site=ehost-live>.
2. L. Koster and H. Nies, "It Takes Three to Tango: An Ethnography of Triadic Involvement of Residents, Families and Nurses in Long-Term Dementia Care," *Health Expectations* 25, no. 1 (2022): 80–90.
3. J. E. Gaugler and L. L. Mitchell, "Reimagining Family Involvement in Residential Long-Term Care," *Journal of the American Medical Directors Association* 23, no. 2 (2022): 235–240.
4. G. Puurveen, J. Baumbusch, and P. Gandhi, "From Family Involvement to Family Inclusion in Nursing Home Settings: A Critical Interpretive Synthesis," *Journal of Family Nursing* 24, no. 1 (2018): 60–85.
5. M. Nolan, J. Brown, S. Davies, J. Nolan, and J. Keady, The Senses Framework: Improving Care for Older People Through a Relationship-Centred Approach, 2006 [Getting Research into Practice (GRiP) Report No 2]; Available from, http://shura.shu.ac.uk/280/1/pdf_senses_framework_report.pdf.
6. S. Busse, E. Tietel, R. Haubl, and H. Möller, *Mit dem Dritten sieht man besser: Triaden und Triangulierung in der Beratung*, (Gottingen: Vandenhoeck & Ruprecht, 2018) (Beraten in der Arbeitswelt).
7. E. Haesler, M. Bauer, and R. Nay, "Staff-Family Relationships in the Care of Older People: A Report on a Systematic Review," *Research in Nursing & Health* 30, no. 4 (2007): 385–398.
8. N. Hovenga, E. Landeweert, S. Zuidema, and C. Leget, "Family Involvement in Nursing Homes: An Interpretative Synthesis of Literature," *Nursing Ethics* 29, no. 6 (2022): 1530–1544.
9. B. McCormack and T. McCance, "The Person-Centred Nursing Framework," in *Person-Centred Nursing Research: Methodology, Methods and Outcomes*, ed. J. Dewing, B. McCormack, and T. McCance (Cham: Springer International Publishing, 2021), 13–27.
10. S. L. Dupuis and J. E. Norris, "A Multidimensional and Contextual Framework for Understanding Diverse Family Members' Roles in Long-Term Care Facilities," *Journal of Aging Studies* 11, no. 4 (1997): 297–325.
11. R. Barken and R. Lowndes, "Supporting Family Involvement in Long-Term Residential Care: Promising Practices for Relational Care," *Qualitative Health Research* 28, no. 1 (2018): 60–72.

12. H. Mayer, S. Köck-Hódi, S. Gschwenter, and M. Wallner, "Personzentrierung aus der Perspektive von An- und Zugehörigen," in *Strategische Überlegungen zur Einbindung der Angehörigenperspektive in die Entwicklung und Evaluation personzentrierter Kultur und Entwicklung eines Messinstruments zur Evaluierung von Personzentrierung* (Karl Landsteiner University of Health Sciences, 2021).
13. A. A. Ryan and H. McKenna, "It's the Little Things That Count'. Families' Experience of Roles, Relationships and Quality of Care in Rural Nursing Homes," *International Journal of Older People Nursing* 10, no. 1 (2015): 38–47.
14. M. Buber, *Ich und Du* (Reclam, 1923) (Reclams Universal-BibliothekNr. 14171).
15. E. Goffman, *The Presentation of Self in Everyday Life*, 1st Anchor Books ed. (New York: Anchor Books, 1959), Available from, <https://ebookcentral.proquest.com/lib/kxp/detail.action?docID=6721863>.
16. J. Baumbusch and A. Phinney, "Invisible Hands: The Role of Highly Involved Families in Long-Term Residential Care," *Journal of Family Nursing* 20, no. 1 (2014): 73–97.
17. S. Davies and M. Nolan, "Making It Better': Self-Perceived Roles of Family Caregivers of Older People Living in Care Homes: A Qualitative Study," *International Journal of Nursing Studies* 43, no. 3 (2006): 281–291.
18. J. Dewing, T. Eide, and B. McCormack, "Philosophical Perspectives on Person-Centredness for Healthcare Research," in *Person-Centred Healthcare Research*, ed. B. McCormack, S. van Dulmen, H. Eide, K. Skovdahl, and T. Eide (2017), 19–29.
19. H. Abels and A. König, *Sozialisation*, (Springer Fachmedien Wiesbaden; Wiesbaden, 2016).
20. L. Moore, N. Britten, D. Lydahl, Ö. Naldemirci, M. Elam, and A. Wolf, "Barriers and Facilitators to the Implementation of Person-Centred Care in Different Healthcare Contexts," *Scandinavian Journal of Caring Sciences* 31, no. 4 (2017): 662–673.
21. M. Summer Meranius, I. K. Holmström, J. Håkansson, et al., "Paradoxes of Person-Centred Care: A Discussion Paper," *Nursing Open* 7, no. 5 (2020): 1321–1329.
22. B. McCormack, "A Conceptual Framework for Person-Centred Practice With Older People," *International Journal of Nursing Practice* 9, no. 3 (2003): 202–209.
23. S. Morgan and L. H. Yoder, "A Concept Analysis of Person-Centered Care," *Journal of Holistic Nursing* 30, no. 1 (2012): 6–15.
24. D. de Silva, *Helping Measure Person-Centred Care: A Review of Evidence About Commonly Used Approaches and Tools Used to Help Measure Person-Centred Care*, (The Health Foundation, 2014), Available from, <https://pascal-francis.inist.fr/vibad/index.php?action=getreferredetail&idt=28671287>.
25. J. Thomas and A. Harden, "Methods for the Thematic Synthesis of Qualitative Research in Systematic Reviews," *BMC Medical Research Methodology* 8 (2008): 45.
26. M. Sandelowski, J. Barroso, and C. I. Voils, "Using Qualitative Meta-summary to Synthesize Qualitative and Quantitative Descriptive Findings," *Research in Nursing & Health* 30, no. 1 (2007): 99–111.
27. V. Braun and V. Clarke, "Reflecting on Reflexive Thematic Analysis," *Qualitative Research in Sport, Exercise and Health* 11, no. 4 (2019): 589–597.
28. D. Byrne, "A Worked Example of Braun and Clarke's Approach to Reflexive Thematic Analysis," *Quality and Quantity* 56, no. 3 (2022): 1391–1412.
29. A. Tong, K. Flemming, E. McInnes, S. Oliver, and J. Craig, "Enhancing Transparency in Reporting the Synthesis of Qualitative Research: ENTREQ," *BMC Medical Research Methodology* 12 (2012): 181.
30. J. McGowan, M. Sampson, D. M. Salzweidel, E. Cogo, V. Foerster, and C. Lefebvre, "PRESS Per Review of Electronic Search Strategies: 2015 Guideline Statement," *Journal of Clinical Epidemiology* 75 (2016): 40–46.
31. J. Hirt, T. Nordhausen, T. Fuerst, H. Ewald, and C. Appenzeller-Herzog, "Guidance on Terminology, Application, and Reporting of Citation Searching: The TARCIS Statement," *BMJ* 385 (2024): e078384.
32. M. J. Page, J. E. McKenzie, P. M. Bossuyt, et al., "The PRISMA 2020 Statement: An Updated Guideline for Reporting Systematic Reviews," *BMJ* 372 (2021): n71.
33. M. Bauer, D. Fetherstonhaugh, L. Tarzia, and C. Chenco, "Staff-Family Relationships in Residential Aged Care Facilities: The Views of Residents' Family Members and Care Staff," *Journal of Applied Gerontology* 33, no. 5 (2014): 564–585 Available from, <https://www.scopus.com/inward/record.uri?eid=2-s2.0-84896805200&doi=10.1177%2f0733464812468503&partnerID=40&md5=669928899710982936e248652b066d47>.
34. J. Holmgren, A. Emami, L. E. Eriksson, and H. Eriksson, "Intersectional Perspectives on Family Involvement in Nursing Home Care: Rethinking Relatives' Position as a Betweenship," *Nursing Inquiry* 21, no. 3 (2014): 227–237 Available from, <https://www.scopus.com/inward/record.uri?eid=2-s2.0-84906261440&doi=10.1111%2fnin.12046&partnerID=40&md5=644eb1e273a687f2baeef0202054a99>.
35. R. Nay, "Relatives' Experiences of Nursing Home Life: Characterised by Tension," *Australasian Journal on Ageing* 16, no. 1 (1997): 24–29.
36. F. Wright, "The Role of Family Caregivers for an Older Person Resident in a Care Home," *British Journal of Social Work* 30, no. 5 (2000): 649–661.
37. E. Woodhall and S. Shaw, "How Close Family Members Contribute to the Occupational Experiences of Their Relatives With Dementia in Long-Term Residential Care: An Interpretative Phenomenological Analysis," *British Journal of Occupational Therapy* 87 (2023): 89–97 Available from, <https://journals.sagepub.com/home/BJO>.
38. M. Petersen, J. Wilson, O. Wright, E. Ward, and S. Capra, "The Space of Family Care-Giving in Australian Aged Care Facilities: Implications for Social Work," *British Journal of Social Work* 46, no. 1 (2016): 81–97 Available from, <https://www.scopus.com/inward/record.uri?eid=2-s2.0-84959875637&doi=10.1093%2fbjsw%2fbcu108&partnerID=40&md5=c2bdd6ff2f78c41d18e3665512cc4cd0>.
39. A. Ahmed, M. E. T. C. van den Muijsenbergh, and H. J. M. Vrijhoef, "Person-Centred Care in Primary Care: What Works for Whom, How and in What Circumstances?," *Health & Social Care in the Community* 30, no. 6 (2022): e3328–e3341.
40. L.-E. Olsson, E. Jakobsson Ung, K. Swedberg, and I. Ekman, "Efficacy of Person-Centred Care as an Intervention in Controlled Trials—A Systematic Review," *Journal of Clinical Nursing* 22, no. 3–4 (2013): 456–465.
41. C. van Diepen, A. Fors, I. Ekman, and G. Hensing, "Association Between Person-Centred Care and Healthcare Providers' Job Satisfaction and Work-Related Health: A Scoping Review," *BMJ Open* 10, no. 12 (2020): e042658.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** Supporting Information. **Data S2:** Supporting Information.