

Interpersonal relationship patterns between family members and older adults in long-term care: a perspective based on family members' experiences

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Abstract

Objective: To analyze interpersonal relationship (IR) patterns between family members and their older relatives during decision-making about, and admission to, a long-term care facility in Colombia.

Methods: An observational study based on case narratives analyzed using the Core Conflictual Relationship Theme method (CCRT-LU). The analysis included 489 relationship episodes (REs) derived from interviews with six family members.

Results: In most REs, the older relative was the relationship partner. Harmonious patterns predominated in family members' desires. In contrast, non-harmonious patterns predominated in their responses and in the desires and responses they attributed to their older relatives. Exploratory episode-level analyses identified associations with some sociodemographic characteristics and living arrangements.

Conclusion: Family members expressed predominantly harmonious desires, emphasizing helping, supporting, protecting, and maintaining closeness. Their responses, however, often reflected non-harmonious patterns involving feelings of depression, disappointment, hopelessness, distress, and frustration. The desires attributed to older relatives included wishes to die, feeling unwell, and dissatisfaction, while their reported responses included behaviors perceived as hostile, threatening, or intimidating.

Housing for the elderly, older adults, family relationships, family

INTRODUCTION

Interpersonal relationships (IRs) involve ongoing or temporary interactions, including friendships, parent–child bonds, romantic relation-

ships, and relationships among colleagues or classmates. They arise from the human need to communicate, obtain support, and ensure survival. Relationships vary in intensity, duration, and meaning, and their quality can influence the happiness, mental health, and overall well-being of those involved.

Family relationships play an important role in family functioning and in the satisfaction, safety, and dignity of individual members. They support a sense of belonging, mutual assistance, emotional expression, and adaptation to change,

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and are therefore important for decision-making during crises [1]. In families with older members, positive relationships with low levels of conflict can facilitate adjustments to aging, particularly when older adults experience declining functional capacity and increasing dependence [2, 3, 4].

Population ageing increases the need for support and long-term care. Many people, particularly at advanced ages, experience declining functional capacity and independence [5, 6]. Research suggests that supporting older adults to remain at home involves at least three key conditions: maintaining a safe home environment, preserving strong interpersonal relationships, and coordinating care with formal healthcare providers [7].

Meeting these conditions can be difficult for families. Unmet needs may affect the safety and well-being of both the older adult and other family members. Admission to a long-term care facility is therefore a growing global trend, particularly when several people require care simultaneously or caregiving demands exceed the family's resources.

Family members' perceptions of admission to long-term care vary and may influence their relationships. The reasons for admission are widely documented. They include clinical conditions, particularly neurocognitive disorders and associated cognitive impairment or behavioral changes, psychiatric diagnoses, limitations in activities of daily living, and physical or psychological symptoms, such as major health events, incontinence, or deteriorating health [8, 9, 10].

Family caregivers' circumstances, including stress, anxiety, sleep deprivation, older age, employment, and higher educational attainment, have also been associated with admission to long-term care [11, 12, 13, 14]. Other reported factors include loneliness, personal preferences regarding future care [15], decisions made by other family members [16], family functioning [14], and the transfer of caregiving responsibilities [17].

Although clinical conditions and family sociodemographic factors are major determinants of admission, individual and family preferences and the characteristics of the support network may also influence the likelihood of entering long-term care [18].

Family caregivers may experience guilt during this process [19]. Guilt has been associated with depression, anxiety, and stress, as well as with caregivers' perceptions of criticism or rejection by the care recipient. One study reported that a model including interpersonal factors explained 28% of the variance in caregiver distress in dementia care. In principle, decisions about admission should be shared and considered together with the older adult to respect their autonomy [20]. In practice, this can be a difficult process involving both negative and positive experiences. Concerns, uncertainty, fear, and family conflict may coexist with recognition of the potential advantages of the care facility over current living conditions [21].

Beyond clinical conditions, caregiver burden, and socioeconomic circumstances, relatively little research has examined the interpersonal relationships between family members and older adults when admission to long-term care becomes necessary. Although previous studies have not always examined interpersonal relationships as their main variable, they suggest that family and social ties support home-based care and help with decisions about admission when needed.

Psychoanalytic and relational approaches examine desires and responses within relationship episodes (REs) to identify relationship patterns (RPs), or characteristic ways of interacting with others. These patterns are understood as unconscious organizing frameworks arising from meaningful interpersonal experiences. They are thought to develop initially through early emotional interactions with parental figures and to influence feelings and behavior in later relationships [22]. The CCRT-LU category system has been adapted into Spanish as CCRT-LU-S [22].

This study identified the desires, needs, and responses that were most prevalent in REs concerning admission to long-term care, as well as the core pattern characterizing these relationships.

METHODS

This observational study used the CCRT-LU method to identify REs and the core theme of relational conflict in participants' case narratives.

PARTICIPANTS

Participants were six members of nuclear families who had been involved in decisions about, and admission of, an older relative to a long-term care facility in Líbano, Tolima, Colombia. Their narratives yielded 489 REs for analysis. Participants were contacted in person or by telephone to arrange interviews at a convenient location, either the facility or their home. Individual interviews were conducted after informed consent had been obtained. Sociodemographic information and details of living arrangements were collected first. Interviews then followed a guide addressing situations within the relationship between the family member and the older relative. Interviews were recorded with permission. Participants were encouraged to discuss their experiences openly, with follow-up questions adapted to the issues emerging from their narratives. Each participant completed one interview lasting no more than one hour. The study was approved by the Ethics Committee of Universidad de Caldas, Colombia (protocol No. 014 of 2023).

Interview guide

- 1. Please tell me about your experience of your family member’s admission to the long-term care facility.
- 2. Can you share any experiences you have had with your older relative?
- 3. What have been the most intense emotions you have experienced in your relationship with this person?
- 4. Can you describe an episode of conflict with your family member?
- 5. Can you describe a positive or pleasant experience with your family member?

DATA ANALYSIS

The data were analyzed using the CCRT-LU method in three phases. First, REs were identified in the narratives, including the relationship partner (the “object” in CCRT terminology), timing, and duration. Interaction components were classified using the Spanish-language adaptation of the method: desires of the

subject (DS), responses of the subject (RS), desires of the object (DO), and responses of the object (RO) [22, 23]. The subject was the interviewed family member. The principal investigator, acting as the first rater, identified and counted the components of each RE and classified them into superclusters, clusters, categories, and subcategories in the CCRT-LU system. The data, including sociodemographic characteristics and living arrangements, were entered into Excel. Second, a second rater evaluated the coding, and agreement was assessed using Cohen’s kappa coefficient (Table 1). Third, the selected REs were analyzed using IBM SPSS, version 24. Descriptive statistics and bivariate analyses were used, including chi-square tests and Kendall’s tau-c. The dependent variables were the identified RPs. Independent variables included participants’ age, gender, marital status, relationship to the older relative, living arrangements, caregiving role, and involvement in decisions about admission.

Table 1. Inter-rater agreement assessed using Cohen’s kappa coefficient

Coding dimension	Cohen’s κ	p value
Interaction components (DS, DO, RS, RO)	0.939	< 0.0001
Direction of components	0.841	< 0.0001
Harmony (harmonious/non-harmonious)	0.965	< 0.0001
Cluster	0.883	< 0.0001
Category	0.851	< 0.0001
Subcategory	0.751	< 0.0001

DS, desires of the subject; DO, desires of the object; RS, responses of the subject; RO, responses of the object.

RESULTS

Participants were aged 32–65 years, with a mean age of 47 ± 11 years. Most were women, and all were married or cohabiting. Most had lived with the older relative and had been their primary caregiver. In all cases, family members had initiated and made the final decision about admission to long-term care (Table 2).

Table 2. Sociodemographic and family characteristics of participants (N = 6)

Characteristic	n	%
Gender		
Female	4	66.7
Male	2	33.3
Marital status		
Married	4	66.7
Cohabiting	2	33.3
Relationship to the older relative		
Son or daughter	3	50.0
Sibling	2	33.3
Spouse	1	16.7
Previous living arrangements		
Lived with the older relative	5	83.3
Did not live with the older relative	1	16.7
Caregiving role		
Primary caregiver	5	83.3
Occasional caregiver	1	16.7
Initiated admission to long-term care		
Family member	6	100.0
Older adult	0	0.0
Made the final admission decision		
Family member	6	100.0
Older adult	0	0.0

Percentages were calculated from the six participants and rounded to one decimal place.

Table 3 presents the REs by participant, relationship partner, timing, and harmony. Responses of the subject (RS) and responses of the

object (RO) accounted for the largest proportions of interaction components. RO were the most frequent and primarily represented responses attributed to older relatives in the reported relationships (Table 4).

Table 3. Relationship episodes by participant, relationship partner, timing, and harmony

Participant	Total REs	Object: older adult	Object: other	Past	Present	Harmonious	Non-harmonious
P1	59 (12.1)	48 (9.8)	11 (2.2)	55 (11.2)	4 (0.8)	21 (4.3)	38 (7.8)
P2	66 (13.5)	55 (11.2)	11 (2.2)	60 (12.3)	6 (1.2)	10 (2.0)	56 (11.5)
P3	80 (16.4)	68 (13.9)	12 (2.5)	80 (16.4)	0 (0.0)	22 (4.5)	58 (11.9)
P4	42 (8.6)	35 (7.2)	7 (1.4)	42 (8.6)	0 (0.0)	24 (4.9)	18 (3.7)
P5	97 (19.8)	94 (19.2)	3 (0.6)	95 (19.4)	2 (0.4)	51 (10.4)	46 (9.4)
P6	145 (29.7)	125 (25.6)	20 (4.1)	114 (23.3)	31 (6.3)	51 (10.4)	94 (19.2)
Total	489 (100.0)	425 (86.9)	64 (13.1)	446 (91.2)	43 (8.8)	179 (36.6)	310 (63.4)

Values are n (%). Percentages refer to all 489 REs. RE, relationship episode. “Object” denotes the relationship partner. Totals may differ slightly from 100% because of rounding.

Table 4. Interaction components by participant

Participant	DS n (%)	DO n (%)	RS n (%)	RO n (%)	Total n (%)
P1	16 (3.3)	5 (1.0)	14 (2.9)	24 (4.9)	59 (12.1)
P2	13 (2.7)	8 (1.6)	17 (3.5)	28 (5.7)	66 (13.5)
P3	21 (4.3)	7 (1.4)	19 (3.9)	33 (6.7)	80 (16.4)
P4	7 (1.4)	5 (1.0)	19 (3.9)	11 (2.2)	42 (8.6)
P5	10 (2.0)	17 (3.5)	24 (4.9)	46 (9.4)	97 (19.8)
P6	27 (5.5)	8 (1.6)	59 (12.1)	51 (10.4)	145 (29.7)
Total	94 (19.2)	50 (10.2)	152 (31.1)	193 (39.5)	489 (100.0)

Percentages refer to all 489 REs. DS, desires of the subject; DO, desires of the object; RS, responses of the subject; RO, responses of the object.

The coding identified six superclusters (two harmonious and four non-harmonious), 13 clusters (four harmonious and nine non-harmonious), 28 categories (nine harmonious and 19 non-harmonious), and 75 subcategories (34 harmonious and 41 non-harmonious). Non-harmonious REs were more frequent at all levels of classification. The distribution of harmonious and non-harmonious REs differed by participants' relation-

ship to the older relative ($p = 0.043$). Non-harmonious REs were more frequent in narratives from women, married participants, and sons or daughters. They were also more frequent among participants who had lived with the older relative and had been primary caregivers, although these associations were not statistically significant (Table 5).

Table 5. Harmonious and non-harmonious relationship episodes by participants' characteristics

Characteristic	Harmonious REs (%)	Non-harmonious REs (%)	p value
Gender			0.667
Female	27.0	47.9	
Male	9.6	15.5	
Marital status			0.090
Married	21.7	32.3	
Cohabiting	14.9	31.1	
Relationship to the older relative			0.043*
Son or daughter	25.4	40.5	
Sibling	2.0	11.5	
Spouse	9.2	11.5	
Previous living arrangements			0.863
Lived with the older relative	32.3	55.6	
Did not live with the older relative	4.3	7.8	
Caregiving role			0.978
Primary caregiver	32.3	55.6	
Occasional caregiver	4.3	7.8	

Percentages refer to all 489 REs. RE, relationship episode. * $p < 0.05$. Reported p values apply to the characteristic as a whole.

INTERACTION COMPONENTS

Desires of the subject (DS): family member toward the older relative

Ninety-four DS were identified: 53.2% were harmonious and 46.8% were non-harmonious. The analysis reported statistically significant differences ($p < 0.0001$), with harmonious desires predominating among family members. The most frequent harmonious RPs were “supporting” (12.0%), “protecting” (8.5%), and “being close, accepting, being intimate, caring, being good, being affectionate” (6.4%). No statistically significant associations were found between DS and participants’ sociodemographic characteristics or living arrangements. The most frequent non-harmonious RPs were “feeling hopeless, suffering, being distressed” (10.6%), “being unhappy, depressed, disappointed” (6.4%), and “feeling frustrated” (5.3%).

Responses of the subject (RS): family member toward the older relative

One hundred fifty-two RS were identified: 60.5% were non-harmonious and 39.5% were harmonious. The analysis reported statistically significant differences ($p < 0.0001$), with non-harmonious responses predominating among family members. The most frequent non-harmonious RPs were “being unhappy, depressed, disappointed” (7.9%), “feeling hopeless, suffering, being distressed” (6.6%), and “feeling frustrated” (5.3%). The most frequent harmonious RPs were “helping, supporting” (11.2%), “being close, accepting, being intimate, caring, being good, being affectionate” (5.3%), and “encouraging, praising, agreeing, motivating, cheering” (3.3%).

Statistically significant associations were reported between RS and previous co-residence with the older relative ($p = 0.047$) and caregiving role ($p = 0.047$). Participants who had lived with the older relative and had been primary caregivers more frequently expressed “helping and supporting” responses. Those who had not lived with the older relative and had provided occasional care more frequently expressed “feeling hurt or offended.”

Desires of the object (DO): older relative toward the family member, as reported by the family member

Fifty DO were identified: 62.0% were non-harmonious and 38.0% were harmonious. The analysis reported statistically significant differences ($p < 0.0001$), with non-harmonious desires predominating in participants’ accounts of their older relatives. The most frequent non-harmonious RPs were “wanting to die, committing suicide” (8.0%), “feeling unwell, feeling dissatisfied” (8.0%), and “feeling hopeless, suffering, being distressed” (6.0%). The most frequent harmonious RPs were “being close, accepting, being intimate, caring, being good, being affectionate” (8.0%), “helping, supporting” (6.0%), and “being ambitious, being conscientious” (4.0%). No statistically significant associations were found between DO and participants’ sociodemographic characteristics or living arrangements.

Responses of the object (RO): older relative toward the family member, as reported by the family member

One hundred ninety-three RO were identified: 74.1% were non-harmonious and 25.9% were harmonious. The analysis reported statistically significant differences ($p < 0.0001$), with non-harmonious responses predominating in participants’ accounts of their older relatives. The most frequent non-harmonious RPs were “torturing, causing physical harm, being hostile, harassing” (15.0%), “frightening, threatening, attacking, provoking” (7.3%), and “bothering, annoying, disturbing, provoking, irritating” (5.2%). The most frequent harmonious RPs were “helping, supporting” (4.1%), “being close, accepting, being intimate, caring, being good, being affectionate” (4.1%), and “protecting” (3.1%).

Statistically significant associations were reported between non-harmonious RO and participants’ relationship to the older relative ($p = 0.033$), with these responses more frequent in narratives from sons or daughters, and participants’ gender ($p = 0.028$), with these responses more frequent in narratives from women.

DISCUSSION

This study identified a core relationship pattern between family members and older relatives admitted to long-term care. Family members tended to express harmonious desires toward the older adult, particularly “helping, supporting, and protecting.” However, non-harmonious patterns predominated in both their own responses and the responses they attributed to their older relatives. The coexistence of harmonious desires and conflicting responses suggests emotional ambivalence in family relationships during the admission process.

Family members’ desires reflected a willingness to provide care and a sense of responsibility for the older relative’s well-being. Admission to long-term care can nevertheless involve substantial changes within the family, including difficult decisions, changes in roles, and emotional demands. These circumstances may help explain why positive intentions coexist with frustration, hopelessness, or sadness.

Participants’ accounts covered different stages of the process, from the emergence of caregiving difficulties to the decision to seek long-term residential care. Both harmonious and non-harmonious REs were identified, with the latter predominating. This suggests that admission may be accompanied by emotional conflict within the family.

Although few studies have used the CCRT-LU method to examine relationships in later life, the findings can be considered alongside earlier research on family relationships and aging. Huo et al. [24] found that empathy supported older adults’ social relationships and more adaptive coping with interpersonal tensions. Birditt et al. [25] reported that reappraising conflicts within family relationships could help preserve emotional well-being. Relationships that allow positive emotional expression and dialogue may also support social skills and problem-solving within families [26].

Harmonious family relationships may be particularly important after admission to residential care. Older adults may experience loneliness as social contact decreases, while regular family contact may help reduce feelings of isolation and rejection [27]. Previous relationship patterns may also shape adaptation to the new environ-

ment and relationships with healthcare professionals [28].

Relationship patterns should be understood as dynamic tendencies that may change over time and with family circumstances. Sullivan [29] described interpersonal relationships as shaped by personality and social context, while relational experiences may also influence personality development across the life course. Personality styles have been associated with interpersonal relationship quality and healthy aging [30, 31].

The non-harmonious patterns identified here reflected participants’ feelings of sadness, frustration, and hopelessness during their relatives’ admission to care. Participants also described their older relatives as experiencing negative emotions or expressing desires related to suffering or dissatisfaction. These findings are consistent with research indicating that prolonged caregiving may increase stress and affect the quality of life of both caregivers and care recipients [31]. Park et al. [13] likewise noted that family relationships may already be strained before admission because of caregiving-related exhaustion, and that residential care may be considered a way to reduce physical, emotional, and financial burdens.

Participants described some responses of their older relatives as hostile, including threatening, provoking, or bothering family members. These accounts are consistent with Gallego-Alberto et al. [19], who linked caregiver guilt to interpersonal experiences involving hostility or conflict avoidance.

The findings are consistent with research describing admission to long-term care as a complex process requiring cognitive and emotional adjustment to a new environment. Feelings of abandonment, loneliness, or rejection may arise, although these experiences may also reflect earlier family relationships.

In the overall comparison by sociodemographic characteristics and living arrangements, the only statistically significant association was with kinship: non-harmonious REs were more frequent in narratives from sons or daughters. This may reflect the central role adult children often play in caregiving and admission decisions. Although no significant associations were found with the other variables in this comparison, non-

harmonious REs were more frequent in narratives from women and primary caregivers.

These findings may also reflect sociocultural aspects of family life in Colombia, where families often provide the main support network for older adults. Intergenerational solidarity, responsibilities toward parents, and close emotional bonds may encourage adult children, particularly women, to become primary caregivers. When caregiving demands increase or persist, caregiver burden and ambivalence about residential care may contribute to relational tensions.

Clinically, the findings suggest that the CCRT-LU method may help practitioners understand family relationships during admission to long-term care. Recognizing the coexistence of harmonious desires and non-harmonious responses may help clarify family members' emotional ambivalence in the context of prolonged caregiving and difficult decisions. Interventions could explore these patterns, support emotional expression, reframe conflicts, and strengthen communication and mutual support. The findings may also inform psychosocial support for family members and older adults adjusting to residential care.

Limitations

The findings cannot be generalized to other settings because only six family members were recruited through a single long-term care facility. The 489 REs are nested within these participants and do not constitute 489 independent respondents. The reported episode-level *p* values should therefore be interpreted cautiously; analyses accounting for clustering would be needed to support participant-level inferences. The sample was also not balanced by sex, family role, or responsibility for admission decisions, limiting comparative analyses. The findings provide an initial descriptive basis for examining relationships during admission to long-term care and illustrate the potential of CCRT-LU to explore family relational dynamics. Future research should include older adults' own perspectives.

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