Research

Beyond Blood Ties: Redefining Family in Pediatric Hospital Care Through a Thematic Analysis of Multistakeholder Perspectives

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Abstract

Introduction. The concept of family in pediatric care is central to the implementation of Family-Centred Care (FCC), yet it remains ambiguously defined in clinical practice. Existing definitions are often limited to traditional structures and rarely reflect the perspectives of children, caregivers, and healthcare professionals.

Methods. A qualitative study using thematic analysis was conducted in a pediatric hospital setting. Semi-structured interviews were carried out with 22 healthcare professionals, 29 caregivers, and 8 adolescents. Data were analysed following an inductive approach. The study was reported according to COREQ guidelines.

Results. Five main dimensions of family emerged: structure, relationship, care and support, context, and choice. The findings highlight a shift from traditional structural definitions toward more relational and subjective understandings. Differences across participant groups were observed: caregivers emphasised structural aspects, while adolescents and healthcare professionals highlighted relational and functional dimensions.

Discussion. The findings support a reconceptualisation of family as a dynamic, multidimensional construct shaped by context and individual perspectives. This has significant implications for the implementation of FCC and the application of the Fundamentals of Care framework in pediatric settings.

Keyword: Family Nursing, Pediatric Nursing, Family, Qualitative Research, Adolescent, Child

Introduction

In recent decades, the concept of family has undergone profound transformations driven by social, cultural, and demographic changes. Traditional definitions, primarily based on biological ties and co-residence, are increasingly insufficient to capture the complexity of contemporary family configurations (Bengtson, 2000; Widmer, 2010). The emergence of single-parent, blended, and same-sex families has contributed to a more dynamic and context-sensitive understanding of family.

In healthcare, particularly in pediatric settings, families are a central component of the care process. The Family-Centred Care (FCC) approach recognises the family as an active partner in the child's care (Kuo et al., 2012; Smith et al., 2017). However, despite its widespread adoption, the literature highlights considerable variability in how "family" is operationally defined, often implicitly restricted to parents or primary caregivers (Coyne et al., 2018).

This conceptual ambiguity has important clinical implications. A restrictive definition may exclude significant individuals in the child's life, potentially compromising the effectiveness of care and limiting the meaningful implementation of FCC (Foster et al., 2019). Furthermore, terms such as "caregiver" do not adequately reflect the complexity of relational networks that contribute to pediatric well-being.

At the same time, the Fundamentals of Care (FoC) framework emphasises that care quality is deeply influenced by interpersonal relationships and by professionals' ability to understand the patient's individual context (Kitson et al., 2014; Feo et al., 2018). Within this perspective, a broader, more nuanced definition of family is essential to ensure genuinely family-centred care.

Despite extensive research on family roles and FCC, a significant gap persists: the lack of a definition of family grounded in the lived experiences of children, adolescents, caregivers, and healthcare professionals in clinical settings (Coyne et al., 2018).

Therefore, this study aims to explore the meaning attributed to the concept of family in a pediatric hospital context through a qualitative analysis of perspectives from adolescents, caregivers, and healthcare professionals. The goal is to contribute to a conceptual redefinition of family as a dynamic, relational, and context-dependent construct capable of supporting clinical practice and the implementation of Family-Centred Care and Fundamentals of Care.

Methods

Study Design

A qualitative study using thematic analysis was conducted to explore in depth the perceptions and meanings attributed to the concept of family in pediatric care. The study was designed and reported in accordance with the COREQ checklist for qualitative research.

Setting

The study was carried out at a major tertiary pediatric hospital in Italy, a national referral centre for pediatric care. Multiple units were involved, including Emergency Medicine, Pediatric Hospice, Cardiovascular Surgery, Oncology Day Hospital, Neonatology, Week Surgery, and Pediatric Endocrinology.

Participants

The sample consisted of three groups: healthcare professionals, caregivers, and adolescents, recruited through convenience sampling.

The healthcare professionals included a multidisciplinary team with experience in pediatric care, including pediatric nurses, physicians, and allied health professionals. Their clinical roles spanned various areas of pediatric practice, providing a broad representation of perspectives within the hospital setting.

Caregivers were primarily parents or primary figures responsible for the child's care during hospitalisation. They represented a heterogeneous group in terms of educational background, caregiving experience, and

familiarity with the healthcare system.

Adolescents were individuals receiving care within the pediatric setting, representing a developmental stage characterised by increasing autonomy and the ability to reflect on personal relationships and social contexts.

Inclusion criteria were the ability to understand Italian and the provision of informed consent. Adolescents were required to fall within a predefined age range (10-19 years) consistent with pediatric care settings.

Data Collection

Data were collected through semi-structured interviews based on two open-ended questions developed from the literature and validated by an expert panel.

The questions were: "Who do you consider part of your family?" and "Who should be considered family during hospitalisation?"

Interviews were conducted in a private setting, audio-recorded with consent, and supplemented by field notes.

Data Analysis

Interviews were transcribed verbatim and analysed using thematic analysis.

Two researchers independently coded the data, identifying codes, categories, and themes. Discrepancies were resolved through discussion with a third researcher.

Analysis was iterative, involving repeated reading and constant comparison. No software was used. Data saturation was reached during data collection and analysis.

Rigor

Methodological rigour was ensured by adhering to Lincoln and Guba's criteria of credibility, transferability, dependability, and confirmability.

Credibility was strengthened by including multiple participant groups (healthcare professionals, caregivers, and adolescents), enabling data triangulation across perspectives. In addition, independent coding by two researchers and subsequent consensus discussions contributed to the robustness of the analytical process.

Dependability was supported by maintaining a clear, systematic analytic process, including iterative coding, documentation of decisions, and regular research team meetings to discuss emerging themes and resolve discrepancies.

Confirmability was addressed by minimising researcher bias through reflexive discussions within the team and by grounding interpretations in participants' narratives. Field notes were used to support contextual understanding and to enhance transparency in data interpretation.

Transferability was facilitated by providing detailed descriptions of the study setting, participant characteristics, and data collection procedures, enabling readers to assess the applicability of the findings to other contexts.

Ethical Considerations

Ethical approval was obtained from the Internal Review Board of IRCCS Istituto Giannina Gaslini prior to the initiation of the study.

All participants received detailed information about the study aims, procedures, and their rights as participants. Written informed consent was obtained from all adult participants. For adolescents, consent was obtained in addition to that of their parents or guardians, in accordance with ethical standards for research involving minors.

Participation was voluntary, and participants were informed of their right to withdraw from the study at any time without any consequences for their care.

Confidentiality and anonymity were strictly maintained throughout the study. Audio recordings and transcripts were securely stored and accessible only to the research team. Any identifying information was removed during transcription to ensure participant anonymity.

Particular attention was paid to the vulnerability of pediatric participants, ensuring that interviews were conducted in a sensitive and age-appropriate manner, minimising any potential discomfort or distress.

Results

Participant Characteristics

The sample included 22 healthcare

professionals, 29 caregivers, and 8 adolescents, providing a broad range of perspectives on the concept of family within pediatric care.

Healthcare professionals were predominantly pediatric nurses (n=18), alongside one physician, one physiotherapist, one radiology technician, and one midwife. The group was mainly female, with a mean age of approximately 45 years. Their clinical experience across multiple pediatric units contributed to a predominantly functional, care-oriented understanding of families.

Caregivers (n=29) were primarily parents, most frequently mothers, with a mean age of approximately 44.5 years. They represented a heterogeneous group in terms of educational background and caregiving experience. Their perspectives were strongly influenced by lived experience and emotional involvement, often reflecting a more structure-oriented yet affectively rich conceptualization of family.

Adolescents (n=8) had a mean age of approximately 14 years and included both males and females. Their accounts emphasised relational and subjective dimensions of family, highlighting autonomy, emotional reciprocity, and the importance of personally meaningful relationships, often extending beyond traditional family boundaries.

Overall, the diversity of participants allowed for a comprehensive exploration of the concept of family, revealing both shared elements and differences across groups.

Thematic Analysis Findings

Five main themes emerged, describing family as a dynamic and multidimensional construct.

Family as Structure

Family was initially described in structural terms, particularly by caregivers, who often referred to the traditional nuclear family, comprising parents and children. This perspective was often grounded in lived experience and caregiving responsibility:

"Since I became a mother, family means my children and my partner."

Caregivers frequently emphasised cohabitation, biological ties, and parental roles as defining elements. However, this structural view was not exclusive.

Healthcare professionals and adolescents expanded this definition by including non-biological and non-cohabiting relationships:

"A group of people connected by marriage, adoption, or affinity." (Healthcare professional)

"My friends, my teammates... they are my family too." (Adolescent)

This variation suggests that while structural definitions remain relevant, they are increasingly permeable and open to broader interpretations depending on perspective.

Family as Relationship

Across all participant groups, family was consistently described as a network of meaningful relationships characterised by affection, trust, and reciprocity.

Adolescents particularly emphasised emotional mutuality:

"Anyone who cares about me and that I care about."

Caregivers highlighted emotional bonds and shared values:

"People who love each other, support each other, and stay together."

Healthcare professionals framed relationships in a slightly more formalised way, emphasising emotional connection as a defining criterion:

"People linked by a bond of affection and emotional closeness."

This theme emerged as a central and shared dimension, suggesting that relational quality often outweighs structural characteristics in defining family.

Family as Care and Support

Family was frequently conceptualised as a system of care and support, particularly by caregivers and healthcare professionals.

Caregivers also described family as those who provide continuous and multidimensional care:

"Those who take care of the child physically, emotionally, and spiritually."

Healthcare professionals extended this definition to include the care team within the hospital context:

"Nurses, doctors, staff... everyone who takes care of the child becomes part of that family in

that moment."

Adolescents emphasised presence and emotional support rather than responsibility:

“People who stay with you and help you when you need it."

This theme highlights how the concept of family in pediatric care may temporarily expand to include healthcare providers, particularly in contexts of vulnerability and hospitalisation.

Family as Context

A less expected but significant dimension was the conceptualisation of family as context, including environmental, symbolic, and experiential elements.

Caregivers and healthcare professionals often referred to routines and familiarity:

"Home, habits, daily life... that's what family is."

Within the hospital setting, this concept extended to recreating a sense of normality:

"Everything that makes the hospital feel a bit like home." (Healthcare professional)

Adolescents were particularly sensitive to this dimension, emphasising continuity between home and hospital:

"When I have my things and feel like myself, that feels like family."

This theme underscores the importance of environmental and contextual factors in shaping the experience of family, especially during hospitalisation.

Family as Choice

The final theme reflects the idea of family as a subjective and individual choice, strongly emphasised by adolescents and supported by healthcare professionals.

Adolescents articulated this clearly:

"Family should be whomever you want next to you."

Healthcare professionals reinforced this patient-centred perspective:

"Family is who the patient identifies as family."

Caregivers showed limited reference to this dimension, tending instead to maintain a more traditional understanding of family grounded in structural and caregiving roles.

This theme aligns with the concept of "family of choice" and highlights the importance of recognizing the patient's perspective in defining family, particularly in pediatric care.

Conceptual Synthesis

The analysis of the interviews highlights that the concept of family in pediatric care is not confined to a single definition but unfolds across five interconnected dimensions: structure, relationship, care and support, context, and choice.

These dimensions emerged consistently across participant groups, although with different emphases depending on the perspective. Caregivers more frequently referred to structural elements, grounding the concept of family in biological ties and caregiving roles. In contrast, adolescents emphasised relational and subjective aspects, while healthcare professionals tended to integrate functional and care-related components into their definitions.

The structural dimension represents the most immediate and socially recognised understanding of family, often serving as an initial reference point. However, it is increasingly complemented by relational elements that shift the focus to emotional bonds, reciprocity, and perceived closeness between individuals.

The dimension of care and support further expands this understanding by framing family as an active system of assistance, particularly relevant in the context of illness. In the hospital setting, this dimension may extend beyond traditional boundaries to include healthcare professionals, reflecting the dynamic nature of caregiving relationships.

The contextual dimension introduces the roles of environment, routines, and familiarity in shaping the family experience. This aspect becomes especially salient during hospitalisation, where maintaining continuity with the child's usual environment contributes to a sense of security and belonging.

Finally, the dimension of choice reflects the subjective nature of family, highlighting the importance of individual perception. This dimension was particularly evident in adolescents' narratives, in which family was defined by personal meaning rather than predefined categories.

Taken together, these findings suggest that family in pediatric care is best understood as a composite construct, in which different dimensions coexist and interact. This conceptualisation provides a framework for interpreting the variability observed across participants and supports the representation of family as a multidimensional system centred on the child, as illustrated in Figure 1.

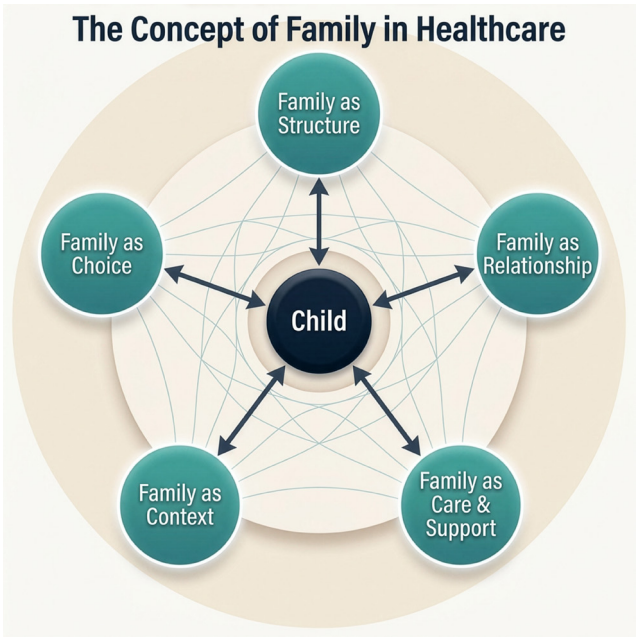

Figure 1. Conceptual model of family in pediatric care showing five interrelated dimensions: structure, relationship, care and support, context, and choice.

Discussion

The findings of this study indicate that the concept of family in pediatric care cannot be reduced to a single, stable definition; rather, it should be understood as a dynamic, multidimensional construct shaped by relational, contextual, and subjective elements. The five dimensions identified—structure, relationship, care and support, context, and choice—provide an empirically grounded framework that reflects how family is experienced within pediatric clinical settings.

A central finding concerns the shift from structural to relational and functional understandings of family. While caregivers more frequently referred to traditional, structure-based definitions rooted in biological ties and parental roles, adolescents and healthcare professionals articulated broader and more inclusive perspectives. This divergence highlights how the meaning of family is not fixed but varies according to experiential position and role within the care process. Similar tensions between structural and relational conceptualisations have been described in the literature, in which family is increasingly recognised as a flexible, socially constructed entity rather than a purely biological unit (Widmer, 2010; Grandclerc et al., 2020).

These findings align with and extend the Family-Centred Care (FCC) framework, which positions the family as a central partner in pediatric care (Kuo et al., 2011). Although the FCC emphasises collaboration and respect for family preferences, it often lacks a clear operational definition of who constitutes "family" in practice (Coyne et al., 2018). The present study contributes to this gap by demonstrating that family should be understood not only in structural terms but also through relational and functional dimensions that reflect the lived experiences of children, caregivers, and healthcare professionals. Recent studies have similarly called for a more flexible and context-sensitive application of FCC, particularly in complex care environments (Foster et al., 2019; Uniacke et al, 2018).

The relational dimension emerged as a core component across all participant groups, suggesting that emotional bonds, reciprocity, and perceived closeness are central to defining family. This supports a shift from asking "who is family" to "what makes someone family," emphasizing the primacy of relationships over formal or biological criteria. Such findings are consistent with previous qualitative research highlighting the importance of emotional connectedness and relational meaning in family definitions (Coyne et al., 2018; Grandclerc et al., 2020).

The care and support dimension further reinforces this perspective by framing the family as an active system of assistance. In the pediatric hospital context, this role may extend beyond traditional family members to include healthcare professionals, particularly during periods of vulnerability. This finding resonates with the Fundamentals of Care (FoC) framework, which emphasises that high-quality care is grounded in relationships and the integration of physical, psychosocial, and relational needs (Kitson et al., 2014; Feo et al., 2018). Recognising who provides meaningful care to the child is essential to delivering holistic, person-centred care.

The contextual dimension highlights the importance of the environment, routines, and familiarity in shaping family experience. Particularly during hospitalisation, the presence of familiar objects, habits, and relational cues can contribute to a sense of continuity and emotional security. This finding underscores the need for healthcare environments to support not only clinical care but also the preservation of the child's everyday life context.

Finally, the dimension of choice underscores the subjective and patient-defined nature of family. Adolescents, in particular, emphasised autonomy in identifying whom they consider family, aligning with the concept of "family of choice" described in sociological literature. This has important implications for clinical practice, as it challenges professionals to move beyond predefined categories and actively engage with the patient's own definition of family.

From a clinical perspective, these findings suggest that pediatric nurses and healthcare teams should adopt a flexible and individualised approach when identifying and involving family members in care. In line with FCC principles, professionals should explicitly ask patients and caregivers whom they consider family and ensure that these individuals are included in communication and decision-making processes. This approach may enhance trust, improve patient experience, and support more effective care delivery.

At an organisational level, the results highlight the need to reconsider policies related to visiting, family presence, and participation in care. Restrictive or standardised definitions of family may inadvertently exclude significant individuals, limiting the effectiveness of family-centred approaches. Adapting institutional policies to accommodate diverse and patient-defined family structures may therefore represent an important step toward more inclusive and responsive care systems.

This study has several strengths, including the inclusion of multiple perspectives and the use of a qualitative approach that captures the complexity of the concept of family. However, some limitations should be acknowledged. The monocentric design may limit the transferability of findings to other settings, and the use of convenience sampling may have introduced selection bias. Future research should explore these findings in multicenter and cross-cultural contexts and examine how different conceptualisations of family influence clinical outcomes and care experiences.

Conclusions

This study highlights that family in pediatric care should be understood as a dynamic, multidimensional, and patient-defined construct rather than a fixed, purely structural entity. The integration of structural, relational, functional, contextual, and subjective dimensions provides a more comprehensive understanding of family as experienced in clinical settings.

Recognising this complexity has direct implications for practice. Adopting a flexible and inclusive approach to defining family may enhance the implementation of Family-Centred Care and support the delivery of care that is truly responsive to the needs of children and their families. In particular, actively involving individuals identified by the patient as significant can strengthen therapeutic relationships and improve care experiences.

From a broader perspective, these findings support the need for healthcare systems to move toward more personalised and context-sensitive models of care. Embedding this conceptualisation of family into clinical practice and organisational policies may represent a key step in advancing pediatric care.

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