

Strategies to manage cognitive dissonance when experiencing resistiveness to care in people living with dementia: a qualitative study

Abstract

Aims: To explore the experiences of healthcare personnel when they face resistiveness to care in people living with dementia in nursing homes

Design: The study has a qualitative explorative design.

Methods: Three focus group interviews were conducted in June 2019. A total of 16 nurses and other healthcare personnel employed in three different nursing homes participated. A semi-structured interview guide was used during the focus group interviews. Data were transcribed verbatim and analysed using an inductive qualitative content analysis.

Results: The analysis generated one overarching category – ‘Tension when facing resistiveness to care’, which describes the discomfort healthcare personnel experienced when confronted with resistiveness to care in people with dementia – and two other categories: ‘Attitude change’ and ‘Changing behaviour’, which describes their strategies to reduce and/or manage the discomfort. Four subcategories – ‘Changing the mindset’, ‘Conceptual shift’, ‘Stepping back’ and ‘Not giving up’ – described the actions taken by healthcare personnel to manage or reduce their cognitive dissonance.

Conclusion: The strategies used to manage or reduce cognitive dissonance provide a new understanding of how healthcare personnel choose to approach resistiveness to care in people living with dementia.

Impact: This study addresses cognitive dissonance, a discomfort experienced by healthcare personnel when facing resistiveness to care from people living with dementia. To reduce their dissonance, the participants employed several strategies, including coercive measures, when providing care. The theory of cognitive dissonance may help explain why healthcare personnel sometimes choose to employ coercive measures while providing care.

Key words: Cognitive dissonance, Content analysis, Dementia, Focus group interviews, Healthcare personnel, People with dementia, Resistiveness to care, Nurses, Nursing homes

1 INTRODUCTION

According to the World Health Organisation (WHO), the age of the global population and number of people living with dementia is expected to triple from 50 million to 152 million by 2050. Dementia is a broad category of progressive neurodegenerative disorders affecting memory, other cognitive abilities and behaviour; dementia also significantly interferes with a person's ability to maintain the activities of daily living (WHO, 2020). Dementia ranges from mild to severe with no clear boundaries and where each person affected by dementia often displays a variation in everyday coping resources, eventually resulting in disability and dependency (Cleret de Langavant et al., 2020). When an individual's physical health deteriorates and the coping resources diminish in a way that the person will no longer be able to perform the tasks of daily living, the person may become increasingly dependent on healthcare personnel, hence culminating in the need for institutional care (Bu & Rutherford, 2019). When people with dementia are living in nursing homes, much of the responsibility for and the power associated with everyday decision making regarding these individuals' lives are left to the healthcare personnel (Goossens et al., 2020). This means that the residents are vulnerable, and the healthcare personnel have power and control over them.

In Western society, autonomy, self-responsibility and informed consent are valued and supported by law (Aiken, 2004). Beneficence is one of the primary values in healthcare (Beauchamp & Childress, 2019). In Norway, patients are protected by the Norwegian government through the Patient and User Rights Act (HOD, 1999) and, similar to other Western countries, by the principle of the patient's right to autonomy and informed consent (Buelens et al., 2016). In dementia care, it is well known that some people living with dementia may say 'no' and resist care, which is a commonly reported feature of caring work

within institutional settings (Ishii et al., 2012). Therefore, when a patient says ‘no’ to care, the nurse must sometimes practice mild paternalism to provide good nursing (Mortensen et al., 2018). Resistiveness to care in older adults who lack capacity to make decisions about personal care, i.e. people living with advanced dementia, may lead to healthcare personnel to employ ‘forced care’ and coercion as a way to manage resistiveness (Watts et al., 2017). Applying paternalism in cases where there is a conflict between the patient’s autonomy and the duty to act for the good of the patient can be perceived as manipulation and coercion (Gjerberg et al., 2016), hence leading to unwanted negative emotions among healthcare personnel. For this reason, healthcare personnel must reflect not only on what they are doing during the provision of care, but also on how they provide care and what attitude they express through their actions if their provision of care should be perceived as respecting or offending the patient’s dignity (Arman & Rehnsfeldt, 2007).

2 BACKGROUND

When exploring the aspects of resistiveness to care in people living with dementia, it is important to define the nature of the problem. The concept of resistiveness to care was defined by Mahoney et al. (1999) as “the repertoire of behaviours with which persons with dementia withstand or oppose the efforts of a caregiver” (p. 28). Later, Ishii et al. (2012) defined a person’s negative behaviours toward care as resistiveness, noncompliance or rejection of care. The definitions are frequently used in nursing, especially within the context of dementia care. The literature reveals several reasons for resistiveness to care, which are often attributed to a combination of patient-related factors, healthcare personnel’s lack of communication and environmental factors (Ishii et al., 2012; Kales et al., 2015).

Over the years, several studies have described the possible interventions that may reduce resistiveness to care in people living with dementia, thus preventing the use of coercion (Gjerberg et al., 2013; Holst & Skär, 2017; Konno et al., 2013; Nordgren, 2018; van

Manen et al., 2021), but very few have revealed healthcare personnel's feelings when facing resistiveness and employing coercive measures to provide care. Holst and Skär (2017) revealed that aggressive behaviours in people living with dementia evoke strong feelings in healthcare personnel, such as fright, uncertainty, tiredness, low self-esteem and negative job satisfaction. Recently, Backhouse et al. (2020) conducted a systematic review revealing that resistiveness to care can be distressing to both the people living with dementia and their caregivers. However, as the literature demonstrates, only a few studies have focused on strategies that healthcare personnel adopt to prevent coercion when facing resistiveness to care in people living with dementia in nursing homes. Although coercion was also suggested as one of the strategies as a last resort, the literature reveals that it still occurs (Ethikrat, 2020; Gjerberg et al., 2016). When beneficence and autonomy are in conflict and coercion is necessary for beneficence, healthcare personnel need a way to resolve this dichotomy and retain their self-esteem. To date, no study has explored how healthcare personnel manage the dichotomy raised when their values and attitudes are not aligned with their desires and behaviours when facing resistiveness to care in people living with dementia. In these instances, healthcare personnel may experience cognitive dissonance, a phenomenon that defines the mental tension arising when conflicting attitudes are held or when behaviours are incompatible with certain attitudes (Festinger, 1957).

Cognitive dissonance is defined as the discomfort experienced by a person trying to meet two or more conflicting demands at the same time or from the demands to engage in activities conflicting with their beliefs or values (Festinger, 1957). A common example of this is a smoker who does not quite smoking, even though he or she is aware of the consequences smoking has on health. Cognitive dissonance theory is attributed to Leon Festinger (1957) and is built on the assertion that individuals strive toward consistence, and when inconsistencies appear, they try to rationalise these to reduce their psychological discomfort.

Festinger (1957) proposed three common ways to reduce dissonance: changing one's cognitions (thereby decreasing the number of dissonant cognitions), creating new consonant cognitions or minimising the importance of dissonant cognitions. Although Festinger (1957) proposed that individuals can reduce dissonance through multiple pathways, the two main alternatives are relevant here: an individual may change oneself in the form of altering his or her attitude and beliefs of action, or the individual can change his or her circumstances, for example, by removing him- or herself from the situation. For healthcare personnel who are continually exposed to aggressive behaviour from people living with dementia in nursing homes, this dissonance might be defined as a discrepancy between providing care in accordance with the nurses' values (Schmidt & McArthur, 2018) and ethical principles (ICN, 2012), hence engaging in activities in conflict with their beliefs (i.e., using coercion to support beneficence). This discrepancy may be relevant because it emphasises the appearance of cognitive dissonance in healthcare personnel.

According to Harmon-Jones (2019), the cognitive dissonance theory has been used in numerous studies of the factors that influence beliefs and attitudes, internationalisation of values and the outcomes of decisions. The theory is taught in business, communication, nursing, and psychology graduate programmes (Gruber, 2003). To the researchers' knowledge, there is a relatively small body of evidence investigating nurses' cognitive dissonance as a research issue in nursing. However, a similar concept known as 'moral distress', which refers to a feeling nurses frequently perceive when they are confronted with ethical dilemmas in their clinical practice (Oh & Gastmans, 2015), is usually used in nursing ethics. Although moral distress is defined as the negative feelings that arise when one knows the morally correct response to a situation but cannot act accordingly because of institutional or hierarchical constraints (Jameton, 1984), cognitive dissonance refers to the personal tension

perceived when an individual's actions contradict or are inconsistent with his or her values or beliefs (Festinger, 1957).

There are a few studies in which the theory of cognitive dissonance was applied in nursing research as a theoretical framework, but none of them used dementia care as the study context. A study conducted by Wiggins (1997) revealed the strategies surgical nurses employed when they perceived a conflict between delivering individualised care and the shift to the increased efficiency and throughput of patients with the move to day cases. The findings from her study revealed that nurses used forms of rationalisation to reduce their cognitive dissonance. Although some of them chose to increase their involvement with a few patients that they felt required individualised care, others argued for maintaining equity of care for all patients, not only for those with increased needs. Another study conducted by Crigger and Meek (2007) explored the psychosocial process that occurs after nurses perceive that they have made a mistake in clinical practice in hospitals. To reduce their cognitive dissonance, the nurses often claimed that the conditions in which the mistake was made contributed to or caused the error, or they diminished the degree of harm caused by the mistake, thus trivialising the incompatibility of being a good nurse and being aware that a mistake had been made.

According to Panghal and Dhanda (2020), the literature on dissonance is largely centred on attitude and behaviour change, two strategies healthcare personnel often choose to reduce the dissonance they feel; therefore, Festinger's (1957) theory of cognitive dissonance was chosen for the current study.

3 THE STUDY

3.1 Aim

The aim of the current study is to explore the experiences of healthcare personnel when they face resistiveness to care in people living with dementia in nursing homes. To understand

their experiences and how they manage these situations, the following research question was formulated: What strategies do healthcare personnel employ to manage resistiveness to care among people living with dementia in nursing homes?

3.2 Design

The current study has an explorative design with a qualitative approach that uses focus-group methodology. The study explores the experiences and feelings of healthcare personnel when they face resistiveness to care in people living with dementia in nursing homes and how they manage this. Given the fact that these are subjective and sensitive topics to discuss, the researchers believed that focus group interviews could help the participants feel less constrained because they would be talking to each other (Barbour, 2018). A focus group would allow the participants to find support in each other, thus encouraging them to open up and share their experiences (Silverman, 2020). Therefore, the study design was chosen as a means of gathering data from opinions, based on participants' thinking and reasoning about their own feelings and experiences, here being prompted and elaborated on in the focus group setting (Barbour, 2018; Silverman, 2020).

3.3 Sample/Participants

To obtain rich information about the research question, it was important to involve participants who were familiar with the topic and had experience working with people living with dementia in nursing homes; therefore, a purposive sampling procedure was chosen. According to Polit and Beck (2020), purposive sampling is typical for qualitative research because it facilitates the understanding of a particular group of people and their activities.

The inclusion criteria for the participants to be included were as follows:

- Registered nurses or auxiliary healthcare personnel
- Employed at a nursing home

- Having experience working with people living with dementia for a minimum of two years.

As a criterion for the selection of the nursing homes and to get a wide range of participants, the nursing homes had to be large and have a special unit for dementia. Formally, the first author sent an application by e-mail to five nursing homes asking for permission to conduct the study; only three answered and gave their approval. After the nursing home leaders gave their approval to conduct the study, they also helped with the recruitment process and invited potential participants to participate. The first author made individual appointments with each nursing home to meet and conduct the focus groups.

In total, 16 participants (15 women and 1 man) with ages varying from 23 to 60 years and work experience ranging from 2 to 38 years, were recruited and participated. Nine participants were registered nurses, and seven were employed as auxiliary healthcare personnel. Within each nursing home, the participants were employed in different units.

3.4 Data collection

Three face-to-face focus group interviews were carried out in June 2019. Two focus groups were conducted with five participants and one focus group with six participants.

The first author moderated all three focus group interviews alone; she has experience in care of the elderly patients, a master's degree in nursing science, and 15 years of experience in facilitating group discussions with nursing students about patient phenomena in nursing.

The first author had not previously met any of the participants. Some of the focus group participants did not know each other beforehand, even though they were employed at the same nursing home. Before starting the interviews, to establish a sense of comfort within the group and promote openness, the first author introduced herself and the project and then asked the participants to introduce themselves and provide information about their age,

education and work experience before each interview session. The participants were also asked for and then provided written consent after detailed information about the research study was given.

The focus group interviews were guided by an interview guide based on a review of the literature that has resistiveness to care as topic. The interview guide was developed by the first author in collaboration with the last author and consisted of five themes with open-ended questions. The following themes were discussed:

- (i) Experiences of resistiveness to care and how it is displayed by residents
- (ii) Situations where resistiveness to care occurs and how often they experience it
- (iii) Employing coercion and providing examples of the types of coercion if they do
- (iv) Managing their feelings when they face resistiveness to care and have to employ coercion
- (v) Suggestions to avoid the occurrence of resistiveness to care, hence avoiding the use of coercion

During the focus group interviews, several follow-up questions were posed to deepen the answers and facilitate a dialogue between the participants that could generate knowledge about their experiences with resistiveness to care and what strategies they can employ to manage resistiveness to care, but also to maintain control and avoid unnecessary digressions.

The interviews were held in a small meeting room at each nursing home in the middle of the participants' working day. Throughout the focus group interviews, the first author observed how the participants were feeling. During the second focus group interview, two participants became uneasy because they were needed at their unit and had to leave the focus group earlier than planned.

The interviews were digitally recorded and lasted between 35 and 55 minutes. After each focus group interview, the first author wrote a link memo summarising her impressions

during the focus groups. These memos were not considered collected data and thus, not analysed. All three interviews were transcribed verbatim, with each author transcribing one interview.

3.5 Ethical considerations

Approval to conduct the study was obtained from the Centre of Development of Institutional and Home Care Services in Oslo, Norway. The study was registered with the Norwegian Centre for Research Data (NSD, Project no. ■■■). Research was conducted in accordance with the Declaration of Helsinki (WMA, 2013), including informed consent, consequences and confidentiality. All the participants received written and verbal information about the study prior to the focus group interviews; they were informed that their participation was voluntary and that they could withdraw from the study at any time without any negative consequences for their employment. They did not receive any financial or other benefits. None of the participants withdrew.

3.6 Data analysis

The focus group interviews amounted to 18,800 words. The text was analysed manually by employing a qualitative inductive content analysis, as described by Kyngäs (2020). An inductive content analysis approach is suitable when the phenomenon under study has not been covered in previous studies or when prior knowledge is fragmented. Healthcare personnel's experiences with resistiveness to care in people living with dementia in nursing homes and their strategies to manage it have not been previously explored; therefore, an inductive content analysis method was chosen. The data were manually analysed. Not using software to analyse data was a conscientious choice because the authors wanted to feel closeness to the data and enhance transparency during the coding process.

A basic inductive content analysis was performed in three steps: data reduction, data grouping and the formation of categories that could be used to answer the research question (Kyngäs, 2020).

Step 1: Each author read and reread all the transcripts sentence by sentence to determine whether each sentence contained information related to the healthcare personnel's experiences with resistiveness to care and how often the participants experience it, if they employed coercion and what they felt about this. This process helped reduce the amount of data. After data reduction, each author read and analysed one interview by him- or herself, here employing an inductive approach. The authors developed open codes separately, such as one word or a shorter sentence. At this step, no theoretical understanding influenced the selection of the units of analysis. Unit selection was based on the themes from the interview guide and derived from the data.

Step 2: All three authors met face to face and discussed the codes from the inductive open coding process, carefully comparing the similarities and differences between the coded data from each interview and sharing their overall understanding of the data. The researchers then discussed and analysed the manifest content, deciding which codes should be grouped together into subcategories and determining the hallmarks of the categories. For example, the codes 'I don't want to use coercion' (FG1, P3) or 'No is a no, and I have to respect it!' (FG2, P5) have gradually been included under one subcategory that, at this step, was influenced by cognitive dissonance theory and that was interpreted as one possible strategy to reduce or/and manage the discomfort participants experienced when confronted with resistiveness to care. These two codes were included under the subcategory labelled 'Stepping back for a while'.

Step 3: The abstraction process continued until the subcategories were grouped into the main categories based on the similarities in content and relationship between them. During this process, the authors' theoretical understanding influenced the abstraction process. For

example, two categories ‘Changing the mindset’ and ‘Conceptual shift’, were included under the main category, ‘Attitude change’, thus addressing one element from cognitive dissonance theory. The analysis was considered complete when theoretical saturation had been reached and the main categories were obtained (Saunders et al., 2018). An excerpt of the development of the coding tree is presented in Table 1.

Table 1 should be inserted here: ...

3.7 Rigour

To enhance the rigour of the study, the authors applied Lincoln and Guba’s (1985) four criteria – credibility, transferability, dependability, and confirmability – to ensure trustworthiness. Moreover, to apply these criteria to enhance the rigour of the study, the authors were inspired by Morrison-Beedy et al.’s (2001) suggestion to establish the trustworthiness of focus group data.

Credibility was ensured by posing open-ended questions during the focus groups interviews; thus, the participants were encouraged to share their perspectives regarding their experiences with resistiveness to care in people with dementia. The authors also offered a detailed description giving examples of how they conducted the analysis of the data at each step.

To support transferability, the researchers provided detailed information about the sample and setting so that readers could recognise and evaluate whether the findings would be applicable to similar contexts with similar populations. Quotes from the participants’ statements are given to support the findings.

To increase dependability, the first author used the same interview guide and posed the same questions to all three focus groups. Each author read and analysed one interview by him- or herself and checked the consistency of the data analysis technique with the other two authors; the authors discussed the analytical process until a consensus was reached.

To enhance confirmability, the authors included excerpts from healthcare personnel's statements, thus verifying the concordance of findings with the raw data. This indicates that the interpretation of the data was not invented or based on preconceived notions.

Reflexivity in qualitative research and the researcher's position at all stages of the research process are important (Berger, 2015). All the authors had clinical experience with dementia care; therefore, they were continuously aware of the impact that their clinical and research backgrounds might have on the analytical process and discussion of the findings. To avoid early interpretation of the data, the authors were aware of their preunderstanding during the analysis. To increase reliability and avoid the risk of overinterpretation, the authors first carried out the analysis alone and then together. The second and third authors did not participate in the data collection, but they were involved in the analysis and discussion, thus acting as peer debriefers. To ensure reflexivity, the authors were as transparent as possible when providing information about all the steps of the research process. Likewise, the findings are presented with the support of quotations from the data. The statements end with a code (a number) assigned to each participant (P) at the beginning of each focus group interview (FG), thus ensuring the quotes' trustworthiness, reflexivity and credibility (Graneheim et al., 2017).

4 FINDINGS

The analysis resulted in one overarching category – 'Tension when facing resistiveness to care' – that describe the discomfort healthcare personnel experienced when confronted with resistiveness to care in people living with dementia. The overarching category is supported by two main categories – 'Attitude change' and 'Changing behaviour' – that describe healthcare personnel's strategies to reduce and/or manage their discomfort. Four subcategories – 'Changing the mindset', 'Conceptual shift', 'Stepping back for a while' and 'Not giving up' – were the actions actually taken to manage or reduce cognitive dissonance. In the following sections, the categories will be presented along with the healthcare personnel's statements.

4.1 Attitude change

All the participants asserted that they wanted to help and provide care, comfort and well-being; they stated that values such as compassion, caring, patience, honesty, integrity, empathy and respect were reflected in their everyday work. However, most of the participants felt that when resistiveness to care occurred, many of these values were put at stake. To reduce discomfort, several of the participants expressed that overall, they had changed their attitudes by altering their internal values and adapting their ideas, beliefs, values and subsequent behaviour to the situation. Their attitudes could be changed by healthcare personnel changing their mindset about how they felt and how they addressed the activities they were engaged within. During the focus group interviews, several participants agreed that they had to lower the demands they placed on themselves and on what they regarded as good care. One participant said as following:

Do they really need to shower? One has to reduce expectations of what good care looks like. Learn to know what they are [the residents] really used to and what is really needed here. We've had some [residents] who were not exactly over hygienic (laughter). We have to see what their needs are, and we have to separate our needs from their needs ... Because we may well need them to shower every day and look clean and neat, but it is not certain that it is their need. (FG1, P5)

Many of them also suggested that the final results had to outweigh the values:

I find it difficult ... but sometimes you have situations ... with... stool, for example ... where you have no choice... and then it is difficult... As an employee you don't have any protection. And it is like ... I have to take you into that shower because you have stool from the chest and down! You just have to give the resident a shower ... So, then you coerce in a way, and you should not do that. Coercion is prohibited.....This is a situation where you just must! Even if you know that the resident really does not want

to take a shower. However, if you know that the resident is happy in the end, when you are done, then it is easier for me to employ a light coercion (laughter) ... But it is difficult when you are in that situation, where you have to find a solution and maybe it is not coercion, but it is... a bit on the border, because you do something you should not... but you see no other solution there and then... (FG2, P2)

Or as one of the participants simply summarised ‘The ends justify the means ...’ (FG2, P3)

4.1.1 Changing the mindset

Several participants asserted that they were aware that good practice in dementia care is about doing activities *with* the residents, focusing on the content of the activities and not doing activities *for* or *to* residents and achieving goals. However, most of the participants expressed the need to change their mindset from one about the content and process to planning and achieving goals if the situation required it, as one of the participants summed up:

This is challenging ... We usually focus on the process and individualised care with meaningful activities and how important they are for the resident; however ... When they [the residents] refuse care, I have to take over and lead them into a comfort situation. With good planning, the time spent with residents who refuse to take a shower is minimal. It may result in achieving the goal ... to help them ... (FG3, P1)

Several participants stated that they were aware that from time to time, they will face resistiveness. They could not change the fact that it could occur during the provision of care, but they would try to change how they thought about it, and they would try to change the way they approached the patient to avoid its occurrence, as the following conversation during the focus group 2 shows:

P1: We sometimes try to alter our body language ...

P5: ... and not only ... and the strength of our voice ... With one patient, I came in and approached him. I said, ‘Good morning!’ and then the resident angrily answered, ‘That

was tough!” (imitating the patient and laughing). I had to lower my voice and speak very softly to him.

P1: Sometimes you must talk in a special way. I experienced this with one of our residents. We had a very good relationship, but it was very difficult to help him. When I was with him, I always had to use a very gentle and light voice. This was a very good method that suits him. But afterwards, I had to lie down for a while. It was very tiring.

P5: We often feel like actors; we change and take on a role every time we approach the residents. Sometimes, you act as a kind of girlfriend or something ... with others, you have to be super strict...

During the focus group interviews, some of the participants revealed experiences of negotiations where agreement was achieved and caring activities completed without coercion. Although providing care by using manipulation and– from time to time– coercion was generally regarded as ‘not a good thing to do’ and was prohibited, coercive activities were sometimes seen as the only feasible way to accomplish something that was assessed as ‘necessary’. Some of the participants referred to situations that demanded decisions and coercive actions be taken if the job should be done:

I felt so bad when one of the residents changed his mind during the shower ... what could I do? Although I tried to negotiate, impasse was reached. He refused everything. However, it would be undignified to let him go. I had to call for assistance, and eventually, we persuaded him to get dressed (FG1, P1)

4.1.2 Conceptual shift

The tension the participants felt was also evident in how they expressed themselves during the interviews. Sometimes, the participants would use concepts like ‘manipulating’, ‘coercing’ and ‘coaxing’, clearly stating that they felt that what they were doing was on the borderline of what was considered acceptable. One participant expressed her uncertainty as follows:

... Although it isn't coercion or physical restraint, I am not sure that it is OK. It is his right to say 'no', but he says 'no' every time I ask him. How long is it acceptable to wait until he says 'yes'? If I take his trousers without his consent, I may be accused of mistreatment. If I let him keep his dirty trousers, I don't do my job! (FG3, P3)

At other times, the participants would use positive words, concepts such as 'leading the patient', 'helping the patient', 'assisting the patient' or 'positive leadership', choosing to define themselves as 'helpers' and their actions as positive caring activities, thus maintaining their internal values, as follows:

We must often give them or exhibit positive leadership of a kind. We have to lead them and make them follow. Because they [the residents] lack the ability to lead themselves. This ability is often what disappears in the course of their illness. (FG1, P5)

To maintain their internal values and manage the discomfort they felt, healthcare personnel had to change their thoughts and think differently about their actions from *with* to *for* and *to*. Most of the participants agreed with the idea, as long as these actions were governed by caring values. One of the participants, having in mind and referring to a particular resident, explained the following:

I have to assess the situation. Sometimes, when she has a good day, she cooperates.

We are doing something together. Other times, when she is passive and doesn't want to do anything, I have to persuade her. I'm starting with doing things for her, and she eventually come along. In both cases, I feel that I am doing good, not harm. (FG3, P5)

For some of the participants, it was easier to manage the discomfort generated by using pressure and coercion if the intention was to help and provide care, as one of the participants expressed: 'It isn't coercion, but caring.' (FG1, P4)

4.2 Changing behaviour

The participants expressed that it was difficult to know how to handle situations in which the residents refused care. Some of them did not want to use coercion, pressure or manipulation choosing to step back from the situation instead. At the same time, the other participants stated that if they respected the residents' refusal of care, they would fail to provide the residents with the necessary care, hence choosing to not give up and persuade the resident. However, in any case, they struggled to strike the right balance between using pressure and coercion and respecting the residents' resistiveness as an autonomous right to say 'no' to care. One of the participants suggested a more pragmatic solution: 'We have two alternatives, fight or flight!'. This meant that healthcare personnel have to choose whether to stay in the situation and handle it or just give up.

The following excerpt from a conversation during the focus group 3 demonstrates how challenging it was to do the right thing:

P5: We have to listen to them! If they do not want to, they don't want to. There is nothing to do about that... If they do not want to shower today, then maybe they want to shower tomorrow ... Maybe they want to shower next week, no one will die from not showering ...

P2 (breaks in): It is very often a gap there ... I mean, there is a gap between the ideal of respecting what the resident wants and the consequences of this decision and that of knowing what he really wants. I think it is always difficult to know if they display resistiveness because they don't want to or because they don't understand.

P5 (continues): Yes, it is not always the case that the person does not want to. Sometimes the person does not understand what is really happening ... so if you explain ... and try to explain again ... and then finally, he understands ... maybe ...

4.2.1 Stepping back for a while

Some of the participants expressed that they had to work with themselves to accept that they could not always change the residents' resistant behaviour; therefore, to manage the discomfort they felt, they changed their attitudes by accepting the residents' resistiveness to care as a dementia symptom and, thus, changed their own behaviour. One of the participants said the following:

I am aware that it is nothing personal ... It is dementia that makes him refuse my help . . . otherwise he would cooperate. I had to say to myself several times that he would accept my help if he could understand what I say ... and I have to accept that I do not succeed every time ... (FG2, P4)

Stepping back was an accepted behaviour in critical situations and a way to manage or reduce the discomfort the participants felt when facing resistiveness to care. When the resident's resistive behaviour was intolerable, the participants thought it was wise to step back and go outside. However, one of the participants expressed helplessness and not being a good care provider when she faced resistiveness to care and had to step back from the situation:

It isn't the end of the world if a resident does not shower every week ... I eventually realised this, but it wasn't easy to accept at the beginning ... sometimes I still feel that I fail ... I have to step back, go out from her room and wait a little bit ... maybe she will cooperate when I come back. (FG1, P2)

Another participant stated that she did not need to 'win all the battles', and her caring values were still the same as they were at the beginning of her career:

If he [a male resident] refuses to shower, it's OK ... It's not easy to accept it, but I have to ... What is my alternative when my persuasion does not work? I don't want to fight to provide care. I am aware that his refusal does not make me a less caring or disrespectful nurse. (FG3, P4)

4.2.2 Not giving up

Although most of the participants admitted that responding to resistiveness to care by ‘stepping back for a while’ was a good way to manage the feeling of discomfort, some suggested that ‘not giving up’ was a better strategy in these situations. However, resistiveness to care was perceived as a graded phenomenon, from not so severe, where the healthcare personnel could easily change a ‘no’ to a ‘yes’, to severe situations, where a ‘no’ always remained a ‘no’, regardless of the healthcare personnel’s effort. Providing support at just the right moment could sometimes contribute to a ‘no’ becoming a ‘yes’ and care activities being completed, thus reducing the discomfort. One of the participants described this as follows:

Sometimes, when they [the residents] say ‘no’ or behave negatively, you may still be able to go through with it. You can talk, and slowly, when they start to move in the right direction, you can support them by encouraging them, ‘Yes, that’s good!’, ‘Come on!’ or ‘This is going well!’ (FG1, P3)

Not giving up was also reflected in how the healthcare personnel interacted and communicated with the residents. The participants limited the possibility of the residents when it came to making choices, informing them about what would happen instead of posing questions or asking about their meaning, as follows:

We don’t ask, ‘Do you want?’ I come into the room and I politely say: ‘Good morning! It’s breakfast time ... I will help you get out of bed!’ (FG1, P3)

One participant explained how she would start a situation when one resident refused to take a shower. She started with something the resident was comfortable with and then slowly disclosed more and more information, leading the resident through the situation:

I start with the feet ... I know that he is familiar with this. I offer a footbath as the first step towards having a shower. He eventually agrees to take a shower when he sees that everything is as he wishes. (FG3, P6)

5 DISCUSSION

The aim of the current study was to explore how healthcare personnel experience resistiveness to care in people with dementia living in nursing homes. Overall, the analysis revealed that the participants were often in morally challenging situations, thus leading to a tension that sometimes exceeded their psychosocial and emotional resources. This tension was generated by the participants' values such as compassion, caring, honesty and respect and attitudes not being aligned with their possible choice of actions when facing resistiveness while they provided care; this is a mental state that Festinger (1957) conceptualised as 'cognitive dissonance'. Once the healthcare personnel experienced cognitive dissonance, they employed dissonance reduction strategies to relieve the emerging negative feeling. When feeling dissonance, the participants were more likely to change their attitudes and behaviours through rationalisation and trivialisation of their thoughts and actions.

The findings demonstrate that if the healthcare personnel respect the resident's autonomy and right of self-determination, it hinders them from doing their job to provide the residents with the necessary care. This caused healthcare personnel moral distress because they were not doing what they knew was right, not knowing what was the right thing to do or both (Fourie, 2015). When healthcare personnel face a choice between providing the residents with necessary care by using coercion or respecting their autonomy, this could be experienced as a psychological response to morally challenging situations, such as moral constraint, moral conflict or both (Fourie, 2015).

To relieve their dissonance while providing care when facing resistiveness, the healthcare personnel employed rationalisation (Festinger, 1957), which is also known as 'making excuses' for their thoughts and actions, thus making the tension they felt consciously tolerable. Although changing their thoughts and how they addressed the employed activities were challenging, they were often seen as reasonable, well justified and even necessary, thus rationalising their self-interest. In their own minds, the participants justified the need for

having the job done and prepared themselves to face the resident's resistiveness and 'be done with it'. The participants re-established their consonance by believing that it was fine to use persuasion and coercive measures when facing resistiveness to care. However, on the other hand, they also rationalise the opposite. 'Stepping back' could also be an excuse to not engage themselves in caring activities, thus leading to the neglect and omission of care.

The healthcare personnel defined themselves as 'helpers', thus relieving the dissonance they felt when using coercive measures. This is in accordance with the findings from a study conducted by Vuckovich and Artinian (2005), where the psychiatric nurses – the participants in the study – used coercion in the context of involuntary care and justified it, thus allowing them to engage in behaviour generally disapproved of while retaining the self-image of a 'good' nurse. In the current study, the participants sometimes also downgraded the value of certain caring activities (e.g., helping with a shower) so that they could 'defend' why the omission of certain activities does not mean lower quality of care and again retain the self-image of a 'good', compassionate, caring, honest and respectful nurse.

However, sometimes, dissonance reduction also depended on the magnitude of dissonance, which was determined by the degree of cognition for each participant. All the participants considered their job as important and valuable and driven by the feelings of responsibility, compassion, respect, honesty and integrity; therefore, the motivation to change their behaviours to reduce dissonance was high. They felt a high level of responsibility for the residents' comfort and well-being so several of the participants decreased the importance of the elements involved in the dissonance by 'trivialisation' (Festinger, 1957). Trivialisation does not reduce the level of dissonance but merely reduces the importance of the dissonance, thus reducing the importance of one or more of the dissonant elements. For instance, the participants felt dissonance when they struggled to strike the right balance between using coercive measures to provide care and respecting the resident's resistiveness as an

autonomous right to say ‘no’ to care. Although some of them chose to ‘step back’ and walk away from the situation, thus reducing their dissonance, others chose not to ‘give up’. In some cases, they did not consider the resident’s ‘no’ as a valid wish and, by blaming the dementia condition and its consequences on the resident’s cognitive function, they provided care despite the resident’s resistiveness. However, according to caring ethics, leaving too many decisions or the wrong type of decisions to a person living with dementia can lead to mistreatment and negligence (Øye & Jacobsen, 2020). The participants felt they had the responsibility and duty to provide the resident with the necessary care; therefore, they minimised the meaning of ‘no’ as an answer coming from a person living with dementia.

In summary, cognitive dissonance theory gives healthcare personnel an opportunity to understand their reactions when facing resistiveness to care in people living with dementia in nursing homes. Exploring how healthcare personnel manage cognitive dissonance when they experience resistiveness to care may help explain why healthcare personnel sometimes employ coercive measures while providing care. Although a relatively new report showed that coercive measures performed with caring or benevolent intent are widespread in health and social services (Ethikrat, 2020), a major idea the current study wishes to convey is that cognitive dissonance theory should not justify using coercion as a standard routine to provide care to residents who display resistiveness to care.

5.1 Limitations

One limitation of the present study is its generalisability. The findings express the views of a few participants recruited from only three Norwegian nursing homes. This may reduce the generalisability of the findings. However, the healthcare personnel who work in the field of dementia may recognise the description of the context, participants and findings. Therefore, the findings may be transferable if the healthcare personnel link them to their own clinical experiences and contexts.

The participants' homogeneity may be considered both a strength and weakness. Homogeneity may also be considered a limitation of the diversity of the interviewees' opinions, which might lead to forming a consensus. However, this was not the case. There was some controversy among the participants during the interviews regarding how they managed their cognitive dissonance. Nevertheless, the richness of the data stems from the participants' willingness to share their strategies to reduce cognitive dissonance.

The findings are grounded in the healthcare personnel's experiences with how they manage cognitive dissonance resulting from engaging in activities that conflict with their beliefs. One weakness is that the study's qualitative nature offers the possibility of alternative explanations of the findings; therefore, the findings cannot be judged and valued as objective truths. However, the findings point to subjective descriptions of how the participants manage their challenging feelings when facing resistiveness to care rather than to statistically verify knowledge and absolute truths.

Another limitation of the study can be in relation to its theoretical perspective. The theoretical perspective could influence the interpretative process in a certain direction. However, this is not the case. This study was not designed with a particular theory in mind. During the focus group interviews, the participants were not asked if they felt cognitive dissonance when they faced resistiveness to care. Festinger's theory was introduced after data were collected and the analysis process had already begun revealing the participants' challenging feelings, 'a tension', when facing resistiveness to care. Moreover, during the interpretative process towards developing an understanding of the empirical data, the content of the categories/subcategories revealed similarities with the strategies suggested by Festinger (1957) for reducing or managing cognitive dissonance. However, the findings of the current study should not be the reason to think that, changing the attitude or changing behaviour are the only strategies healthcare personnel can use to manage their cognitive dissonance. Other

researchers, by using other theoretical framework would likely develop alternative strategies to manage the discomfort healthcare personnel may experience when engaging in activities conflicting with their beliefs or values.

Focus group interviews were moderated by the first author alone. This may be seen as a limitation regarding data collection because it is possible that the moderator could have missed important information that would enrich the data. A secretary could have taken notes throughout the discussion, assessed the participants' facial expressions and body language, gave an oral summary and debriefed with the moderator at the end of sessions. However, the moderator wrote memos at the end of each focus group summarising her impressions, and thus making sure that important information that could be interpreted as data was not missing.

Another weakness concerns the possibility of repeating focus group interviews, returning the transcripts to participants or conducting member checks to improve the credibility of the data because of the challenges of gathering the same sample of healthcare personnel to validate their statements. However, during the interviews, all the participants confirmed and reinforced their statements, affirming that there was nothing more to add, suggesting that they had given detailed information.

6 CONCLUSION

While trying to satisfy the wishes of residents and provide the necessary care, the healthcare personnel were torn between respecting residents' autonomy and providing care by coercion. For most of the participants, this was perceived as psychologically uncomfortable, resulting in tension that needs to be managed if the result is to provide care to people with dementia who consistently say 'no' to care.

The description of the strategies used to manage or reduce cognitive dissonance provides a new understanding of how healthcare personnel choose to approach resistiveness to care. Cognitive dissonance is not a negative experience in and of itself because it forces

healthcare personnel to think critically. On the contrary, from a clinical perspective, cognitive dissonance presents opportunities to extend healthcare personnel's clinical maturity.

However, healthcare personnel without sufficient theoretical and ethical knowledge and without sufficient clinical experience from working with people living with dementia, may be overwhelmed in trying to manage their own cognitive dissonance. This may result in feelings of fear, uncertainty, tiredness and negative feelings regarding job satisfaction (Holst & Skär, 2017). Therefore, healthcare personnel who work in the field of dementia care should be aware of the phenomenon and, thus, be able to reflect on their own attitudes and behaviours and which approaches may help them manage – and eventually reduce – cognitive dissonance. However, healthcare personnel's awareness does not lead to less tension when facing resistiveness to care. To manage cognitive dissonance and, at the same time, be able to carry on the provision of care while facing resistiveness, healthcare personnel need to be supported by colleagues and the leadership of the organisations. In conclusion, there is a need for further research to clarify what constitutes ethical, moral and lawful approaches in influencing healthcare personnel's attitudes and behaviours and, thus, in managing cognitive dissonance without compromising the relationship between the patient's autonomy, beneficence and act of duty.

ACKNOWLEDGEMENTS

The authors are grateful to the participants who shared their time and experiences during the focus group interviews.

CONFLICT OF INTEREST

The authors declare that there are no potential conflicts of interest.

References

Aiken, T. D. (2004). *Legal, Ethical, and Political Issues in Nursing* (2nd ed.). Pa: F.A. Davis.

- Arman, M., & Rehnsfeldt, A. (2007). The 'Little Extra' That Alleviates Suffering. *Nursing Ethics*, 14(3), 372-386. <https://doi.org/10.1177/0969733007075877>.
- Backhouse, T., Dudzinski, E., Killeth, A., & Mioshi, E. (2020). Strategies and interventions to reduce or manage refusals in personal care in dementia: A systematic review. *International Journal of Nursing Studies*, 109, e103640. <https://doi.org/https://doi.org/10.1016/j.ijnurstu.2020.103640>.
- Barbour, R. (2018). *Doing focus groups* (U. Flick, Ed., 2nd ed.). SAGE Publications.
- Beauchamp, T. L., & Childress, J. F. (2019). *Principles of Biomedical Ethics* (8th ed.). Oxford University Press.
- Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research*, 15(2), 219-234. <https://doi.org/10.1177/1468794112468475>.
- Bu, F., & Rutherford, A. (2019). Dementia, home care and institutionalisation from hospitals in older people. *European Journal of Ageing*, 16(3), 283-291. <https://doi.org/10.1007/s10433-018-0493-0>.
- Buelens, W., Herijgers, C., & Illegems, S. (2016). The View of the European Court of Human Rights on Competent Patients' Right of Informed Consent. Research in the Light of Articles 3 and 8 of the European Convention on Human Rights. *European Journal of Health Law*, 23(5), 481-509. <https://doi.org/10.1163/15718093-12341388>.
- Cleret de Langavant, L., Bayen, E., Bachoud-Lévi, A.-C., & Yaffe, K. (2020). Approximating dementia prevalence in population-based surveys of aging worldwide: An unsupervised machine learning approach. *Alzheimer's & Dementia: Translational*

Research & Clinical Interventions, 6(1), e12074.

<https://doi.org/https://doi.org/10.1002/trc2.12074>.

Crigger, N. J., & Meek, V. L. (2007). Toward a theory of self-reconciliation following mistakes in nursing practice. *Journal of Nursing Scholarship*, 39(2), 177-183.

<https://doi.org/10.1111/j.1547-5069.2007.00164.x>.

Ethikrat, D. (2020). *Benevolent Coercion—Tensions between Welfare and Autonomy in Professional Caring Relationships*. German Ethics Council. Retrieved from:

<https://www.ethikrat.org/fileadmin/Publikationen/Stellungnahmen/englisch/opinion-benevolent-coercion.pdf>.

Festinger, L. (1957). *A Theory of Cognitive Dissonance*. Row Peterson.

Fourie, C. (2015). Moral Distress and Moral Conflict in Clinical Ethics. *Bioethics*, 29(2), 91-

97. <https://doi.org/https://doi.org/10.1111/bioe.12064>.

Gjerberg, E., Hem, M. H., Førde, R., & Pedersen, R. (2013). How to avoid and prevent coercion in nursing homes: a qualitative study. *Nursing Ethics*, 20(6), 632-644.

<https://doi.org/10.1177/0969733012473012>.

Gjerberg, E., Lillemoen, L., Pedersen, R., & Førde, R. (2016). Coercion in nursing homes.

Nursing Ethics, 23(3), 253-264. <https://doi.org/doi:10.1177/0969733014564907>.

Goossens, B., Sevenants, A., Declercq, A., & Van Audenhove, C. (2020). Improving shared decision-making in advance care planning: Implementation of a cluster randomized

staff intervention in dementia care. *Patient Education and Counseling*, 103(4), 839-847. <https://doi.org/10.1016/j.pec.2019.11.024>.

- Graneheim, U. H., Lindgren, B. M., & Lundman, B. (2017). Methodological challenges in qualitative content analysis: A discussion paper. *Nurse Education Today*, 56, 29-34. <https://doi.org/10.1016/j.nedt.2017.06.002>.
- Gruber, M. (2003). Cognitive dissonance theory and motivation for change: a case study. *Gastroenterology Nursing*, 26(6), 242-245. <https://doi.org/10.1097/00001610-200311000-00005>.
- Harmon-Jones, E. (Ed.). (2019). *Cognitive Dissonance: Reexamining a Pivotal Theory in Psychology* (2nd ed.). American Psychological Association.
- Holst, A., & Skär, L. (2017). Formal caregivers' experiences of aggressive behaviour in older people living with dementia in nursing homes: A systematic review. *International journal of older people nursing*, 12(4). <https://doi.org/10.1111/opn.12158>.
- ICN (2012). *The ICN Code of Ethics for Nurses*. <http://www.icn.ch/images/stories/documents/publications/ind/indkit2012.pdf>.
- Ishii, S., Streim, J. E., & Saliba, D. (2012). A conceptual framework for rejection of care behaviors: review of literature and analysis of role of dementia severity. *Journal of the American Medical Directors Association*, 13(1), 11-23.e11-12. <https://doi.org/10.1016/j.jamda.2010.11.004>.
- Jameton, A. (1984). *Nursing practice: the ethical issues*. Prentice-Hall.
- Kales, H. C., Gitlin, L. N., & Lyketsos, C. G. (2015). Assessment and management of behavioral and psychological symptoms of dementia. *Bmj*, 350:h369. <https://doi.org/10.1136/bmj.h369>.

- Konno, R., Stern, C., & Gibb, H. (2013). The best evidence for assisted bathing of older people with dementia: a comprehensive systematic review. *The JBI Database of Systematic Reviews and Implementation Reports*, 11(1), 123-212.
<https://doi.org/10.11124/jbisrir-2013-607>.
- Kyngäs, H. (2020). Inductive Content Analysis. In H. Kyngas, K. Mikkonen, & M. Kääriäinen (Eds.). *The Application of Content Analysis in Nursing Science Research* (pp. 13-21). Springer Nature Switzerland AG 2020. <https://doi.org/10.1007/978-3-030-30199-6>.
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.
- Mahoney, E. K., Hurley, A. C., Volicer, L., Bell, M., Gianotis, P., Hartshorn, M., Lane, P., Lesperance, R., MacDonald, S., Novakoff, L., Rheume, Y., Timms, R., & Warden, V. (1999). Development and testing of the Resistiveness to Care Scale. *Research in Nursing & Health*, 22(1), 27-38. [https://doi.org/10.1002/\(sici\)1098-240x\(199902\)22:1<27::aid-nur4>3.0.co;2-t](https://doi.org/10.1002/(sici)1098-240x(199902)22:1<27::aid-nur4>3.0.co;2-t).
- Morrison-Beedy, D., Côté-Arsenault, D., & Feinstein, N. F. (2001). Maximizing results with focus groups: Moderator and analysis issues. *Applied Nursing Research*, 14(1), 48-53.
<https://doi.org/https://doi.org/10.1053/apnr.2001.21081>.
- Mortensen, A. H., Nordhaug, M., & Lohne, V. (2018). Nudging in nursing. *Nursing Ethics*, 26(6), 1601-1610. <https://doi.org/10.1177/0969733018779226>.
- Nordgren, A. (2018). How to respond to resistiveness towards assistive technologies among persons with dementia. *Medicine, Health care and Philosophy*, 21(3), 411-421.
<https://doi.org/10.1007/s11019-017-9816-8>.

- Oh, Y., & Gastmans, C. (2015). Moral distress experienced by nurses: a quantitative literature review. *Nursing Ethics*, 22(1), 15-31. <https://doi.org/10.1177/0969733013502803>.
- Panghal, A., & Dhanda, B. (2020). Cognitive Dissonance, Attitude Change and Ways to Reduce Cognitive Dissonance: A Review Study. *Journal of Education, Society and Behavioural Science* 33(6), 48-54. <https://doi.org/10.9734/JESBS/2020/v33i630236>.
- Patient and User Rights Act (1999). *The Patient and User Rights Act* [In Norwegian], (LOV-1999-07-02-63). Retrieved from: <https://lovdata.no/dokument/NL/lov/1999-07-02-63>.
- Polit, D. F., & Beck, C. T. (2020). *Nursing research : generating and assessing evidence for nursing practice* (11th International ed.). Lippincott Williams & Wilkins.
- Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity*, 52(4), 1893-1907. <https://doi.org/10.1007/s11135-017-0574-8>.
- Schmidt, B. J., & McArthur, E. C. (2018). Professional nursing values: A concept analysis. *Nursing Forum*, 53(1), 69-75. <https://doi.org/10.1111/nuf.12211>.
- Silverman, D. (2020). *Interpreting qualitative data* (6th ed.). SAGE.
- van Manen, A. S., Aarts, S., Metzelthin, S. F., Verbeek, H., Hamers, J. P. H., & Zwakhalen, S. M. G. (2021). A communication model for nursing staff working in dementia care: Results of a scoping review. *International Journal of Nursing Studies*, 113, e103776. <https://doi.org/https://doi.org/10.1016/j.ijnurstu.2020.103776>.
- Vuckovich, P. K., & Artinian, B. M. (2005). Justifying coercion. *Nursing Ethics*, 12(4), 370-380. <https://doi.org/10.1191/0969733005ne802oa>.

Watts, S. J., Jackman, L., & Howarth, A. (2017). 'Speaking about the unspeakable': Clinical psychologists views on the role of the profession regarding 'forced care' of older adults without capacity. *Dementia*, 18(2), 660-673.

<https://doi.org/10.1177/1471301216688545>.

WHO (2020). *Dementia. Fact sheet*. World Health Organisation. Retrieved from Media centre: <http://www.who.int/mediacentre/factsheets/fs362/en>.

Wigens, L. (1997). The conflict between 'new nursing' and 'scientific management' as perceived by surgical nurses. *Journal of Advanced Nursing*, 25(6), 1116-1122.

<https://doi.org/10.1046/j.1365-2648.1997.19970251116.x>.

WMA (2013). World Medical Association Declaration of Helsinki: Ethical principles for medical research involving human subjects. *JAMA*, 310(20), 2191-2194.

<https://doi.org/10.1001/jama.2013.281053>.

Øye, C., & Jacobsen, F. (2020). Informal use of restraint in nursing homes: A threat to human rights or necessary care to preserve residents' dignity? *Health*, 24(2), 187-202.

<https://doi.org/10.1177/1363459318800175>.