social sciences

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Back to Kindergarten? Paternalistic Care Behavior in Healthcare Contexts and Older Adults' Mental Health

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Abstract: Objectives: Paternalistic care behavior in health contexts reduces involvement in the decision-making process and dissatisfaction in healthcare, which may negatively influence older adults' mental health. This study comprised two main objectives: (1) to explore older adults' experiences of paternalistic behavior in the context of health services and (2) analyze the influence of paternalistic behavior on older adults' mental health. Methods: The sample involved 416 participants aged 65 to 81 ($M = 70.1 \pm 5.73$) with three different nationalities (English, Brazilian ad Portuguese). All interviews went through content analysis. Results: For the first objective, content analysis identified seven themes: (1) perceived inattention to the uniqueness of each person (81%); (2) feeling a duality of supporting and suppressing independence (79%); (3) selective disclosure of information to keep the person's spirit up (74%); (4) feeling neglected (66%); (5) feeling unable to make decisions (64%); (6) receiving opposition to the person's requests (60%); and (7) routine actions being considered as the best action (57%). For the second objective, three main themes emerged: (1) feeling anxious and stressed (88%); (2) feeling frustration and despair (87%); and (3) feeling injustice and anger (72%). Conclusions: Healthcare paternalism negatively affects older adults' mental health, emphasizing the need for their agency, involvement in decisions, and personalized care. These findings highlight the negative influence of paternalistic behavior on the mental health of older adults and may contribute to future targeted interventions and policy programs among the older population.

Keywords: healthcare; healthy aging; mental health; older adults; paternalistic care behavior

Citation: von Humboldt, Sofia, Sara Silva, and Isabel Leal. 2024. Back to Kindergarten? Paternalistic Care Behavior in Healthcare Contexts and Older Adults' Mental Health. *Social Sciences* 13: 437. https://doi.org/10.3390/socsci13090437

Academic Editor: Barbara Fawcett

Received: 12 June 2024
Revised: 10 August 2024
Accepted: 12 August 2024
Published: 23 August 2024

1. Introduction

The worldwide population of older adults is predicted to increase from 11% to 22% by 2050, and chronic diseases will account for 23.1% of the global burden of illnesses (von Humboldt et al. 2013; von Humboldt and Leal 2017; Rababa et al. 2020). This significant demographic shift underscores the importance of understanding and addressing the unique healthcare needs of an aging population. The concept of an aging population is a recent theme from a historical perspective, highlighting the urgent need to adapt healthcare practices and policies to better assist older adults (von Humboldt et al. 2022).

Examining these needs through diverse cultural lenses is crucial, as cultural contexts significantly influence individuals' perceptions of health and their experiences within healthcare systems (von Humboldt et al. 2022). Moreover, the literature reiterates the need for a deep understanding of how cultural factors intersect with paternalistic behavior, and how these can lead to more effective, respectful, and personalized care strategies which may address the varied expectations of older adults from distinct cultural backgrounds (von Humboldt et al. 2013).

Since the COVID-19 pandemic and the significant disruption to daily life and health accessibility, which followed the pandemic years, researchers have explored its effect among different populations. However, older adults have been specifically underrepresented in the literature, with their needs and experiences often not being recognized, despite being the

population at the highest risk of health complications, including psychological problems and death (von Humboldt et al. 2022; World Health Organization 2021).

Moreover, the experience of depression, loneliness, anxiety, and emotional instability in older adults can lead to hypertension, inflammation, and elevated stress hormone levels, consequently reducing their quality of life and increasing the risks of conditions like dementia, strokes, and mortality (Koma et al. 2020). Mental disorders, such as depression in older adults, can result in more functional impairments and hinder recovery from other medical conditions, including bone fractures (Webb and Chen 2022).

The type of care required by older adults varies based on their physical, psychological, and social conditions, as well as the caregivers' knowledge, abilities, and perspectives on aging (Fernández-Ballesteros et al. 2019). Discrimination, neglect, and disparagement toward older adults have been on the rise, undermining the recognition of their needs and perpetuating paternalistic perceptions (Vale et al. 2020; Rahman and Jahan 2020; Lichtenstein 2021; Ayalon et al. 2021; Ayalon 2020; Petretto and Pili 2020; Morrow-Howell et al. 2020; Cesari and Proietti 2020; Brooke and Jackson 2020).

According to Dworkin (2015), paternalism is the belief that individuals are better suited to protect or advance the interests of others by making decisions on their behalf. Paternalism also involves attitudes of overprotection, seen as an infringement on personal freedom and autonomy, driven by beneficent intent (Fernández-Ballesteros et al. 2019). Sánchez-Izquierdo et al. (2019) describe paternalism as an attitude where the caregiver assumes a superior position over the care recipient, leading to a passive role for the patient. While clinicians often hold this perspective, family members also often approach care recipients through this lens, intending the best for their loved ones (Sánchez-Izquierdo et al. 2019; Thompson et al. 2022). Similarly, gerontological centers tend to infantilize older adults, by using childish language and offering excessive signs of affection, which can reinforce perceptions of their illness or disability (Sánchez-Izquierdo et al. 2019). These approaches underestimate older individuals' capabilities and sense of agency and fail to treat them as competent adults, leading to unnecessary help and attempts to restrict their activities, creating an environment of overprotection for those who do not ask for or require such protection (Fernández-Ballesteros et al. 2019).

The conventional belief that people with serious mental illnesses frequently lack the mental capacity to understand their treatment needs often validates the use of paternalistic interventions, which are well-intentioned measures designed to restrict a person's freedom of choice (Sánchez-Izquierdo et al. 2019). The concept of autonomy is frequently associated with the freedom to choose (Molina-Mula and Gallo-Estrada 2020). Limiting older adults' autonomy can hinder the attainment of a good quality of life, and by expanding opportunities for choice, we improve older adults' freedom and well-being and enable them to express their identities and to achieve precisely what they desire (Sánchez-Izquierdo et al. 2019).

Additionally, older patients may become more dependent as a result of paternalistic attitudes and behaviors, which are frequently seen as diminishing human independence and autonomy (Sánchez-Izquierdo et al. 2019, 2022).

Implementing behavioral interventions based on the guidelines of behavioral therapy, which may include professional training, intends to identify and transform paternalistic behaviors, for example, by using techniques like modeling, role-playing, and reinforcement of autonomous behaviors (Sánchez-Izquierdo et al. 2019). According to Sánchez-Izquierdo et al. (2019), when older adults were asked about their preferred treatment, they expressed a desire to be treated as adults with dignity, autonomy, and respect.

Cultural differences significantly impact preferences for and experiences of paternalistic versus autonomous physician behaviors. Thompson et al. (2022) highlighted that Mexican patients generally viewed paternalism positively, while White American patients preferred autonomy and viewed paternalism negatively. This underscores the importance of considering cultural context when evaluating paternalistic practices in healthcare.

Paternalistic attitudes in healthcare can significantly impact patients' autonomy, recovery, and mental health (Sánchez-Izquierdo et al. 2019, 2022). Murgic et al. (2015) highlight

that while patient autonomy is a fundamental principle of medical ethics, it has historically been challenged by paternalistic practices. Paternalism in healthcare, characterized by overprotection and limited communication, undermines shared decision-making and patient autonomy, which are crucial for mental health and recovery. Lazcano-Ponce et al. (2020) found that explicit communication and lower levels of paternalism are associated with better outcomes. Therefore, it is essential for medical professionals to promote patient autonomy and integrate it into their clinical practice, as sponsoring independence and explicit communication are vital for recovery and mental health and for reducing the adverse effects of paternalism (Murgic et al. 2015).

To date, very few studies explore paternalistic behavior among health professionals towards older adults in different cultural contexts. Hence, it is pertinent to explore how older adults feel in the context of health and how it influences their mental health. Therefore, the present study aims to address the following objectives: first, to explore older adults' experiences of paternalistic behavior within health services, and second, to analyze the influence of such paternalistic behavior on older adults' mental health.

2. Method

2.1. Recruitment and Sampling

In total, 450 older adults were contacted for this study; however, 34 were excluded because they were unavailable or because the data they provided were incomplete. As a result, 416 older adults were integrated into the overall sample. The sample included participants aged between 65 and 81 years old ($M = 70.1 \pm 5.73$), recruited in the Metropolitan area of Lisbon and in the Algarve, Portugal, to examine potential differences and similarities in experiences and outcomes across diverse cultural contexts. These participants were of three different nationalities (36.3% Brazilian; 30.5% English; 33.2% Portuguese). Since participants showed different nationalities, they embodied diverse cultural backgrounds. English and Brazilian older participants who composed the sample chose Portugal as their residential country for their retirement years. Additionally, Brazilian participants added a distinct cultural perspective due to the significant cultural differences between South America and Europe; 63.1% of the participants were female, 65.2% lived with another person, and only 18.1% received a high school education (see Table 1). The assessment of income, education, and living arrangement variables provided relevant insights into how these participants were characterized in terms of these socio-demographic variables.

In total, 88.3% of the participants attended community healthcare centers, 11.5% attended local hospitals, and 0.2% were visited by multidisciplinary teams, (e.g., composed of a nurse, a doctor, and a clinical psychologist) in their homes. Additionally, data on the severity of the illness being treated indicated that 92.6% of participants received ambulatory care, 6.4% were on bed rest at home, 0.8% required immobilization, and 0.2% received palliative care in their homes.

Participants had to fulfill the following criteria in order to take part in this study: (a) age of 65 or older; (b) comprehension of the decision to participate in the study; (c) no history of cognitive impairment functions, such as psychiatric or neurological conditions or drug or alcohol abuse; and (d) familiarity with technologies (e.g., apps, smartphone, computer, tablet, etc.). The fulfillment of these criteria was operationalized through a comprehensive questionnaire focused on self-reported psychological symptoms of psychiatric and neurological conditions or substance abuse, ensuring their eligibility before considering them for inclusion in the study.

These criteria were chosen to ensure the reliability and validity of the study outcomes. Specifically, the exclusion of participants with a history of cognitive impairment was necessary because these impairments could have significantly biased the narratives of these participants. Moreover, familiarity with technologies ensured that participants could effectively respond to questionnaires and interact with the study tools, thereby reducing barriers to participation and ensuring that technological issues did not influence the data collection.

Table 1. Sample of socio-demographic and health characteristics.

Characteristics	Portuguese 138 (33.2)	Brazilian 151 (36.3)	English 127 (30.5)	Total 416 (100.0)
Age, Average ± SD				70.3 ± 5.76
Biological Sex, *n* (%)				
Female	85 (61.5)	92 (61.1)	85 (67.2)	262 (63.1)
Male	53 (38.5)	59 (38.9)	42 (32.8)	154 (36.8)
Education, *n* (%)				
Primary school	79 (57.2)	69 (45.9)	59 (46.4)	207 (49.8)
Middle school	36 (26.0)	56 (36.8)	42 (33.1)	134 (32.1)
≥High school	23 (16.8)	26 (17.3)	286(20.5)	75 (18.1)
Household				
Live with someone	86 (62.7)	106 (70.3)	79 (61.9)	271 (65.2)
Live alone	52 (37.3)	45 (29.7)	48 (38.1)	145 (34.8)
Family Annual Income, *n* (%)				
EUR ≤ 25,000	36 (25.9)	34 (22.8)	49 (38.4)	119 (28.6)
EUR > 25,000	102 (74.1)	117 (77.2)	78 (61.6)	297 (71.4)
Perceived Health, *n* (%)				
Good	80 (57.9)	93 (61.9)	73 (57.1)	246 (59.1)
Poor	58 (42.1)	58 (38.1)	54 (42.9)	170 (40.9)

Participants were recruited in lifelong learning centers, message boards, personal emails, and community center listservs. It was possible to comprehensively explore paternalistic care behavior in health contexts and its influence on older adults' mental health, by conducting semi-structured interviews. Participants were clearly informed that the study focused on examining paternalistic behavior in healthcare settings. Regarding the ward setup, these participants attended healthcare contexts, in which staffing numbers ranged from 20 to 950 staff members.

The interviews were conducted in Portuguese and English, based on participants' language fluency, with subsequent transcription and translation to ensure accuracy across languages. The language used for interviews was initially established by the participants, in order to ensure that all participants were fluent in the interview language, thereby ensuring accurate communication and data collection. After confirming the availability of both participants and interviewers, the interviews lasted approximately 30 min.

Before the beginning of the study, the objectives of the study were explained to the participants, and that participant responses would remain anonymous. With their informed consent, participants were interviewed using Zoom, WhatsApp, and Skype. Any issues were addressed by phone or online support.

All the interviewers had a background and deep experience in gerontology and paternalistic behaviors in healthcare contexts, and they ensured that participants had a clear understanding of the concept of paternalism, before addressing the key interview questions. In relation to this, at the beginning of each interview, a detailed explanation of paternalistic behavior according to Sánchez-Izquierdo et al. (2019) was provided to the interviewees, also covering behaviors and attitudes (e.g., infantilizing an older person, assuming an older person is constantly at risk or senile, excluding an older person) that collectively make up paternalism in healthcare. Paternalism was explained comprehensively to these older participants as an assembly of behaviors and attitudes in a healthcare approach, where decisions are made by the provider with minimal input from the patient, often under the assumption that this approach is in the patient's best interest. To aid in comprehension, we used specific examples of paternalistic behavior, such as instances where patients felt their preferences were disregarded or when decisions were made on their behalf without their involvement. Participants' understanding of this concept was also verified through follow-up questions. Specifically, we asked them to provide a fictional example of a situation in which paternalism could be observed in a healthcare setting.

Next, the interview's two main questions were presented as the following: "Could you tell us about your experience of paternalistic behavior in the context of health services?" and "In your opinion, how did paternalistic care behavior in health contexts affect your mental health?". The interview questions were designed to elicit detailed accounts of personal experiences with paternalistic behavior and its effects on mental health. Moreover, the questions allowed participants to express their experiences freely, without leading or biasing their responses with predefined queries. By providing a clear definition and examples, we aimed to minimize confusion and ensure that participants could provide informed responses about their experiences and perceptions.

Member checking contributes to the accuracy and validity and was performed informally during the interviews when interviewers summarized and confirmed their interpretation of the participants' narratives. This approach allowed us to validate our interpretations and maintain trustworthiness and authenticity towards older participants' perspectives throughout the following analysis process.

Interviews were held over three months in 2022 (June to August). The entire transcription and translation were completed later for a more in-depth analysis. The 1964 Declaration of Helsinki and all amendments thereto, as well as any other ethical standards, were followed in all steps. These were approved by the ethics committee of ISPA—Instituto Universitário and the Research Ethics Committee of the William James Center for Research.

2.2. Data Analysis

The data analysis was conducted using content analysis through a systematic step-by-step approach (Erlingsson and Brysiewicz 2017). First, all data were transcribed verbatim. To create an organized analysis and a code list, an alpha-numeric code was initially assigned to each unit sense which emerged from the narratives. Each interview was individually coded by three Portuguese researchers. The relationship between sub-themes, themes, and categories and respective coding was systematically elaborated: sub-themes delineated specific aspects within themes (e.g., not being heard), themes represented overarching concepts, which grouped sub-themes (e.g., lack of responsiveness), and categories were hierarchical classes, based on shared characteristics of emerging themes from the narratives (e.g., feeling neglected) (Erlingsson and Brysiewicz 2017).

Categories fulfilled the general guidelines for classifying qualitative data, including (a) homogeneity (existing common elements); (b) relevance (significance of categories); and (c) objectivity and fidelity (objective and reliable categories). These guidelines were systematically followed throughout the whole process. A matrix for the interpretation of results was built for the theoretical and empirical discussion of the data in two phases: descriptive analysis and qualitative analysis of the categories that emerged. The level of implication allowed in the analysis was limited to the exploration of qualitative findings within the scope of the predefined categories. The three researchers brought rich experiences to the study, which enhanced the analysis and interpretation of findings. All disagreements were resolved upon discussion. The inter-researcher reliability was high ($0.79 < k < 0.91$, p-value < 0.01, p-value ≤ 0.05) in all analyses.

3. Results

3.1. Older Adults' Experiences of Paternalistic Behavior in the Context of Health Services

The first objective of this study is to explore older adults' experiences of paternalistic behavior in the context of health services. The analysis revealed seven significant categories describing the experiences of older adults in healthcare settings: (1) perceived inattention to the uniqueness of each person (81%); (2) feeling a duality of supporting and suppressing independence (79%); (3) selective disclosure of information to keep the person's spirit up (74%); (4) feeling neglected (66%); (5) feeling unable to make decisions (64%); (6) receiving opposition to the person's requests (60%); and (7) routine actions being considered as the best action (57%).

3.1.1. Theme 1: Perceived Inattention to the Uniqueness of Each Person

Showing no consideration for the person's uniqueness was the most frequent category; 81% of participants (n = 295) expressed how they felt that the healthcare system overlooked the individuality of each patient. This theme was mainly verbalized by Brazilian and Portuguese participants. They voiced worries about how medical staff members appeared to disregard their particular requirements, needs, and preferences in favor of standard operating procedures or general interventions. Sarah verbalized, "Sometimes, I do not feel as a person. Professionals fail to recognize how special my situation is. I've frequently thought that a broad approach to care ignores my unique requirements and values. This disrespect, to my particular situation, result in a feeling of devaluation and disempowerment". (Sarah, female, 72 years old). Ian also stated, "I feel that receiving specialized treatment is essential to preserving my mental health as an older adult. My general well-being is improved when medical personnel take the time to hear my worries, have meaningful dialogues with me, and take into account my needs. Unfortunately, that is not always the case" (Ian, male, 67 years old).

3.1.2. Theme 2: Feeling a Duality of Supporting and Suppressing Independence

The second most verbalized theme was feeling a duality of supporting and suppressing independence, which was mentioned by 79% of participants. This theme was mostly mentioned by English participants. They had the impression that the healthcare system approached their independence in two different ways. There were times when they were supported, but there were other times when their independence seemed to be restrained. Susan verbalized, "I have come across healthcare workers who truly respect my independence. They support my decisions, give me a voice in the process, and take the time to listen. However, I have occasionally felt as though my independence was ignored. Some healthcare professionals made assumptions about my needs without seeking my input. Feeling as though I have no say in matters affecting my own health is upsetting" (Susan, female, 65 years old). Anne explained, "I had this fantastic encounter with a healthcare professional during my routine check-up who actually recognized my independence and included me in the decision-making process. But after I was brought to the hospital, things started to change. However, the medical staff appeared to utterly ignore my autonomy. They made choices without asking or considering what I desired. I was feeling powerless. It is depressing to observe the huge contrast between how the healthcare system promotes or stifles my freedom" (Anne, female, 77 years old).

3.1.3. Theme 3: Selective Disclosure of Information to Keep the Patient's Spirit Up

Theme 3 was verbalized by 74% of participants, and mainly by English older participants. These participants reported that they often received selective or intentional suppression of information within the context of healthcare. Healthcare practitioners can give confusing information regarding the patient's health state and treatment alternatives in an effort to keep the patient's spirits up or retain an optimistic perspective. However, this strategy could have unforeseen effects that harm the patient's health. Thomas said, "Although I am aware of their good intentions, it can be annoying and even hurtful to my wellbeing. I firmly think that in order to make educated decisions and actively participate in my own care, I must be fully informed about my medical condition and available treatments. When I hear ambiguous information, it makes me feel hesitant, confused, and even distrustful of the healthcare system" (Thomas, male, 69 years old). Diana also stated, "They were reluctant to reveal the entire depth of my condition during my recent hospitalization, perhaps in an effort to keep me positive and create a pleasant environment. Transparency and open communication, even if it meant addressing uncomfortable facts, would have better helped my general well-being during that period, since I felt confused and unsure about the genuine nature of my condition" (Diana, female, 71 years old).

3.1.4. Theme 4: Feeling Neglected

Feeling neglected was expressed by 66% of participants, and this was mostly indicated by Portuguese participants. Despite seeking medical care and assistance, older adults reported situations in which they felt that medical staff lacked attention, responsiveness, and empathy. Filip verbalized, "There were times when I felt unheard and disregarded because my worries and inquiries were brushed off or disregarded. My whole experience was damaged by this feeling of neglect, which also made me lose trust in the hospital system" (Filip, male, 85 years old). Also, Eric mentioned, "In one particular case, I sought advice from a physician about a condition I had been having. But he hardly gave me a chance to voice my worries before prescribing a generic medication. I felt dismissed and that my concerns were unimportant as I walked out of the session. This made me wonder if my health was actually receiving the attention it required" (Eric, male, 81 years old).

3.1.5. Theme 5: Feeling Unable to Make Decisions

In total, 64% of participants verbalized their experiences of feeling unable to make decisions within the healthcare system. This theme was most indicated by Brazilian participants. There were times when they felt a lack of agency and involvement in decisions regarding their own health, impacting their sense of autonomy, trust in the healthcare process, and overall engagement in their own care. Antonia verbalized, "I was provided little information throughout a difficult medical treatment and was confused by the technical language. I felt that the medical staff made all the decisions for me and that I was not included in the process. I feel disempowered and cut off from the healthcare experience since I can't decide what's best for my own health" (Antonia, female, 66 years old). Dean explained, "There have been times when I've felt that choices were made without me or taking my preferences into account. One instance was when I received a prescription for a new drug without being informed of any possible side effects or alternatives to treatment. My opinion didn't seem to be appreciated, which made me feel dissatisfied and powerless" (Dean, male, 72 years old).

3.1.6. Theme 6: Receiving Opposition to the Person's Requests

In total, 60% of participants discussed how they had encountered opposition to their desires inside the healthcare system. Portuguese participants mostly verbalized this theme. They felt frustrated and helpless, and that their needs and concerns were not being taken seriously as a result of the opposition to their requests. Jim verbalized, "I clearly recall a circumstance in which I asked for a certain test to look into my symptoms in more detail. The medical professional disregarded my request, saying, "We don't usually perform that test unless it's absolutely necessary." It was quite upsetting, and this encounter made me doubt the quality of our healthcare system" (Jim, male, 87 years old). Hugo also explained, "I had used a medication in the past and had positive results. It helped me with my pain. But the medical professional, who disagreed and showed hesitation, said to try a new one because that medication wasn't right for my situation. It was quite upsetting, and I wanted my opinion to be heard and my prior experiences to be considered" (Hugo, male, 77 years old).

3.1.7. Theme 7: Routine Actions Being Considered as the Best Action

The last topic was verbalized by 57% of participants, and especially by Brazilian participants, expressing their experience of routine actions being considered as the best course of action within the healthcare system. The participant described situations in which medical personnel appeared to rely on default procedures or standardized protocols, overlooking their unique needs and circumstances. Telma mentioned, "I had been dealing with constant pain, and when I went to the doctor, they instantly prescribed a generic drug without doing any additional research or taking into account my particular symptoms. Instead of taking the time to comprehend my particular circumstance, it seemed as though they were simply following a standard process" (Telma, female, 66 years old). Ryan stated,

"My circumstance appeared to the healthcare practitioner to be just another normal issue. I began to wonder if this was really the best course of action for me. It's crucial to go beyond regular procedures and make sure that every patient receives the best, most individualized treatment possible, taking into consideration their unique circumstances and a variety of potential outcomes" (Ryan, male, 70 years old).

3.2. How Paternalistic Behavior Affects the Mental Health of Older Adults

The second objective of this study is to explore how paternalistic behavior affects the mental health of older adults. Three major themes related to the influence of paternalistic behavior on older adults' mental health: (1) feeling anxious and stressed (88%); (2) feeling frustration and despair (87%); and (3) feeling injustice and anger (72%).

3.2.1. Theme 1: Feeling Anxious and Stressed

In total, 88% of participants expressed feelings of anxiety and stress resulting from experiences of paternalism within healthcare settings, which can have implications for their overall mental well-being. This theme was mostly verbalized by participants from the three nationalities. Liam verbalized, "I feel anxious and... stressed, very stressed. It weakens my sense of control and agency when choices concerning my health are made without consulting me or taking my preferences into account. It's upsetting to believe that I have no influence over choices that have a direct impact on my wellbeing" (Liam, male, 86 years old). Rita also said, "It increases anxiety and stress levels since I'm continuously worried about the results and if my issues are being taken seriously. Healthcare professionals must understand that integrating older people in decision-making may reduce these emotions, fostering a sense of empowerment and improving general mental health" (Rita, female, 67 years old).

3.2.2. Theme 2: Feeling Frustration and Despair

The feeling of frustration and despair was the second theme, expressed by 87% of participants in healthcare environments. This theme was mostly verbalized by Portuguese participants. They spoke of how deeply hurt they felt when healthcare professionals overlooked or discarded their worries, preferences, and opinions. Pia said, "It makes me feel hopeless and helpless when my ideas, worries, and preferences are ignored or discarded. I feel... frustration and... despair. It's genuinely depressing to know that decisions about my wellbeing are being made without taking my personal choices into account" (Pia, female, 80 years old). Kim also verbalized, "I tried to trust the healthcare system, but I start to doubt it when there is a lack of regard for my point of view and whether or not my well-being is actually a top priority. To be honest, my mental health suffered as a result of these sentiments of frustration and despair" (Kim, female, 91 years old).

3.2.3. Theme 3: Feeling Injustice and Anger

The third theme was expressed mostly by English participants and by 72% of participants in general. Participants verbalized the experience of feeling injustice and anger as a result of paternalistic behavior within healthcare settings, experiencing unjust treatment, being denied the chance to control their own health, and the anger that followed. Will explained, "It makes me feel as my rights are being violated when paternalistic behaviors are foisted upon me. I become angry and irritated because I'm not allowed to participate in making my own healthcare decisions. My anger is fueled by this sense of injustice because I feel that I should have the freedom to make responsible decisions for my own well-being" (Will, male, 82 years old). Nicole said, "There was a time when a healthcare professional disregarded what I suggested without giving them any thought and opted for a traditional strategy instead. It seemed unjust that my wishes to investigate non-traditional medical approaches were ignored without a sincere debate or consideration. I felt that I had been unfairly denied this privilege, which just made me more enraged and made me doubt the system's impartiality" (Nicole, female, 69 years old).

4. Discussion

This study aimed to achieve two objectives: first, to delve into older adults' experiences of paternalistic behavior within health services, and second, to explore the effects of such behavior on their mental health.

4.1. Older Adults' Experiences of Paternalistic Behavior in the Context of Health Services

For the first objective, seven categories emerged from our analysis: (1) perceived inattention to the uniqueness of each person (81%); (2) feeling a duality of supporting and suppressing independence (79%); (3) selective disclosure of information to keep the person's spirit up (74%); (4) feeling neglected (66%); (5) feeling unable to make decisions (64%); (6) receiving opposition to the person's requests (60%); and (7) routine actions being considered as the best action (57%).

The most frequent reported theme, "perceived inattention to the uniqueness of each person", emerged from the analysis of participants' responses, indicating a prevailing concern among older adults regarding the lack of individualized attention in healthcare interactions. This theme was particularly emphasized by Brazilian and Portuguese participants. According to the literature, paternalistic care is common in formal settings and affects the autonomy of older adults (Sánchez-Izquierdo et al. 2019). The level of autonomy promotion depends on the older adult's resources and can be tailored to each patient (Fernández-Ballesteros et al. 2019).

Professional health caregivers, namely physicians, nurses, and other health professionals, may adjust their care behaviors to align with the specific functional abilities, preferences, and needs of older adults to whom they are attending. This approach may ensure that care is personalized and responsive, enhancing the effectiveness and quality of support provided (Fernández-Ballesteros et al. 2019). Additionally, according to Fountouki et al. (2020), nurses require specific training that encompasses addressing the unique requirements of their patients and interpreting their messages and behaviors sensitively. This training should emphasize patient-centered care principles, ethical decision-making frameworks, and cultural competence to ensure that nurses respect and prioritize the beliefs and values of patients, while providing effective and humanized care.

However, addressing paternalism in healthcare settings requires more than one single training session or one-off training module. The deep-rooted nature of paternalism and its intersection with authoritarianism in healthcare suggests that transformation must focus on shifting from a purely professional-centered approach to one that values patient engagement and cooperation in care settings. Recognizing patients as co-producers of care, rather than passive recipients, is essential for improving therapeutic relationships and patient dignity (Avci 2023). Moreover, as Burgess et al. (2011) pointed out, since paternalism and authoritarianism can be deeply intertwined, and the influence of medical authoritarianism on treatment decisions and physician attitudes further complicates the dynamics of care, specialized training for health professionals is crucial in these contexts.

The second most verbalized theme, "feeling a duality of supporting and suppressing independence", encapsulates the complex emotions and perceptions of older individuals who grapple with the contradictory dynamics of both receiving support and feeling their independence being stifled. English participants were the most verbal about this theme. Pourgholam et al. (2022) indicated that older adults are appreciative of healthcare; however, they also feel helpless, desperate, and unable to make decisions since they have lost their freedom. An important ethical concept in patient care should be the practice of supportive care behaviors that place a strong emphasis on patient involvement (Pourgholam et al. 2022).

Current models of care emphasize patient-centeredness and patient involvement; however, paternalistic care persists in practice. To unsettle these power dynamics, actions are needed to promote shared decision-making (e.g., confirmation of healthcare professionals' interpretation of their patients' requests) to empower patients in their care decisions (e.g., online communication and decision-making) and to ensure that healthcare providers

prioritize patient autonomy and their preferences (e.g., tailored interventions focused on aging in place of older populations) (Burgess et al. 2011; Murgic et al. 2015). Caretakers, on the other hand, frequently disregard older individuals' abilities, adhering to stereotypes in the process; they do not treat them as adults, offer irrational assistance, and make an effort to limit their activities. The paternalistic approach frequently occurs when caregivers overprotect cared-for individuals (Sánchez-Izquierdo et al. 2019).

Selective disclosure of information to keep the patient's spirit up was the third most referred theme and highlighted the experiences of older individuals who reported receiving ambiguous or unclear information, presumably to preserve their good mood and positive view. This theme was mostly verbalized by English participants. By boosting patients' strength, knowledge, and self-confidence, healthcare professionals can encourage patients to take an active role in their care (Fountouki et al. 2020). Older adults need to communicate all of their health concerns, as well as have the right to be fully informed of any activity relating to their health, unless it is expressly restricted by legislation. Moreover, older adults who lack access to medical expertise now have online resources, which may allow them to learn more about their health and healthcare processes (Fountouki et al. 2020).

Healthcare professionals should make sure that all information is provided so that the patient can make an informed decision while still being respected for their autonomy. The goal in this regard is to inform and assist older patients in developing and maintaining a sincere interest in and responsibility for their own well-being (Fountouki et al. 2020). Many older adults did not receive adequate information about their health condition, leading to a lack of awareness and reduced self-worth (Fuseini et al. 2022); hence, the lack of autonomy and the inadequate involvement of patients in decisions are a barrier to the sense of agency of older adults, making them feel worthless, powerless, and not in control of care decisions (Bridges et al. 2020; Fuseini et al. 2022).

Participants also indicated that they felt neglected. These underscored the salience of this aspect in their experiences of paternalistic behavior within healthcare services. Portuguese participants mostly reported this theme. Hierarchical decision-making is frequently the norm in care facilities for older people (Fountouki et al. 2020). Because of their medical condition, infirmity, or disability, older individuals are frequently treated like children, needing security and overprotection from caretakers, through the use of infantile vocabulary with plenty of diminutives, and even with exaggerated displays of affection (Fountouki et al. 2020).

Moreover, in the study by Fernández-Ballesteros et al. (2019), participants indicated that they would like to be treated as adults (not as children), to be able to choose, to be treated with dignity and respect, and to be informed and asked. Caretakers overprotect the care receiver who neither requests nor needs protection when they undervalue the capacities of older adults, treat them like an infant, provide needless assistance, and try to limit their activities (Fuseini et al. 2022). Furthermore, older adults in our study reported feeling neglected or unattended, especially when they were in pain or needed empathy. Similarly, in another study, patients emphasized how important it was for them to be treated with respect and dignity (e.g., asking permission to enter a room) (Fuseini et al. 2022).

The fifth most reported theme that emerged from the participants' accounts was "feeling unable to make decisions", reflecting a sense of disempowerment and frustration, as they perceived their autonomy being undermined within healthcare settings. Brazilian older adults particularly emphasized this theme. Nurses are essential to older patient care because they interact with patients and their families more frequently than other members of the treatment team (Font-Jimenez et al. 2020). These authors noted that this puts nurses in an excellent position to empower and encourage patients to take an active role in their own treatment. Once nurses delegate decision-making to older patients, they should provide patients more control over their treatment so they can take an active role in their own care (Pourgholam et al. 2022).

It must be noted that the shift of power from nurses to older patients is a difficult process, although evidence suggests that nurses engage in paternalistic care behaviors

(McCullough et al. 2021). Patients can make decisions about their own illnesses and medical processes with the help of experts thanks to an equitable power distribution.

Additionally, participants also expressed the theme of "receiving opposition to the person's requests", highlighting the challenges older adults face when encountering resistance from healthcare providers in expressing their preferences or needs. This theme was mostly pointed out by Portuguese older adults. It is believed that those receiving care take a passive role. Clinicians typically occupy this position and aim to choose what is best for their patients. Additionally, family members frequently approach those in their care from this vantage point, wishing only the best for their loved ones while perhaps underestimating their capabilities and preferences (Sánchez-Izquierdo et al. 2019).

The literature indicates that there are misunderstandings about older adults, who are thought to be uneducable, impatient, annoyed, and temperamental as well as incapable of adapting to new settings (Gholamzadeh et al. 2022). Older people highlight that medical staff frequently disregard frail older patients and list them as low-priority patients for examinations and treatments (Gholamzadeh et al. 2022). Inequality in the provision of medical and nursing care results from discriminatory attitudes based on age and the degree of a person's impairment, which can have a negative impact on the amount and quality of care provided to older people as well as the success of their treatment (Wyman et al. 2018).

Last, routine actions being considered as the best action was pointed out by these participants, illustrating how their individual needs were overlooked in favor of standardized or routine approaches within healthcare services. This theme was mostly referred to by Brazilian participants. For a variety of reasons, including thinking that routine activities are the best actions, avoiding patient irritation, or adhering to the doctor's directions, healthcare professionals can put patients in a foggy state of awareness regarding their own illnesses (Pourgholam et al. 2022). In a previous study, older participants also claimed that their medical staff equated problems with old age and assumed that all seniors experienced poor vision, hearing, and memory (Gholamzadeh et al. 2022).

Additionally, the health team believed that disorientation, forgetfulness, and a lack of cognitive function are natural aspects of aging. These caused them to view caring for older patients as being time-consuming and futile, and to treat them differently (Gholamzadeh et al. 2022). Moreover, health professionals' attitudes and perceptions towards older adults are frequently unfavorable, biased, and negative (Heydari et al. 2019). More research has similarly revealed age-biased attitudes, or the generalization of age-related deficits (e.g., bad sight, hearing, and memory) to all older people (Wyman et al. 2018). These myths may have a negative impact on healthcare decision-making, resulting in poor diagnosis and treatment, disregard for patients who are older adults, and disparities in the delivery of nursing and medical care (Wyman et al. 2018).

The differences observed among participants from different nationalities highlight the complex interplay between cultural context and the perception of paternalistic behavior. Brazilian older adults' emphasis on feeling unable to make decisions and perceived inattention to their uniqueness suggests a pronounced sensitivity to autonomy and personal acknowledgment, potentially reflecting a cultural value placed on individual agency and personal recognition. In contrast, Portuguese participants focused on feeling neglected and expressed frustration and a sense of injustice, which may indicate a heightened expectation for empathy and respect in interactions, possibly linked to cultural norms around interpersonal respect and support. English participants emphasized the duality of supporting versus suppressing independence and selective disclosure of information, which suggested a nuanced experience where the balance between autonomy and paternalism was particularly salient. These differences underscore the importance of tailoring healthcare approaches to accommodate varying cultural expectations and values related to the autonomy and dignity of older adults to whom they are attending (Heydari et al. 2019).

4.2. How Paternalistic Behavior Affects the Mental Health of Older Adults

The second objective of this study was to explore how paternalistic behavior affects the mental health of older adults. Our findings revealed three significant categories: feeling anxious and stressed (88%), feeling frustration and despair (87%), and feeling injustice and anger (72%).

Feeling anxious and stressed was the most verbalized category by all the nationalities. Chronic illnesses and economic issues are the main sources of stress among older people, and stress is a prevalent mental health issue that impacts the senior population's quality of life (Seangpraw et al. 2020; van Leeuwen et al. 2019). In the study of Fuseini et al. (2022), about the perceptions and experiences of dignified care for hospitalized older adults, the authors indicated that being paternalized, for example, by providing insufficient information or not being provided any information, made older adults feel anxious and doubtful, emphasizing the importance of receiving health information that could improve their emotional well-being, and make them feel secure.

Participants felt frustrated and in despair due to paternalistic behavior within healthcare services. Portuguese participants strongly expressed this theme. Despair brought on by a lack of autonomy is another topic that arises from patients' lived experiences in other studies. Indeed, older adults felt hopeless and powerless in making decisions for themselves when they realized they had lost their freedom (Chung et al. 2020). When health professionals hand over control to patients, they must encourage patients to take an active role in their own care (van Leeuwen et al. 2019; Pourgholam et al. 2022). Additionally, being self-sufficient gives them the opportunity to enjoy life and feel free to socialize, go outside, and do anything they want.

Independently carrying out everyday tasks and routines helps one feel in control (van Leeuwen et al. 2019). Moreover, our older participants stressed that being dependent or old does not exclude one from being able to voice out their needs or make decisions.

Last, participants also emphasized that they felt injustice and anger due to perceived dismissals of their preferences and autonomy. English participants mostly verbalized this theme. Older patients often feel angry, humiliated, and distrustful towards health staff because of a lack of respect for their dignity (Fekonja et al. 2022). In addition, the study of Fekonja et al. (2022) emphasized that the dependence on care personnel and confinement of older persons also made them powerlessness. Moreover, inadequate and disrespectful healthcare can evoke feelings of suffering, sadness, and anger among older individuals who are confined to their beds (Clancy et al. 2021; Fekonja et al. 2022). Furthermore, participants may experience feelings of injustice due to receiving paternalistic care, where an unequal distribution of power between caretakers and patients can potentially influence the level of commitment from the patient to support the caretaker's decisions (McCullough et al. 2021).

Despite the differing emphases observed in the first objective across nationalities, the three groups consistently reported heightened levels of anxiety and stress as a result of paternalistic behavior. This shared experience underscores the significant impact of paternalistic care on mental health, highlighting that issues of anxiety and stress transcend cultural differences and affirm the critical need for sensitive, person-centered care practices across all healthcare settings.

4.3. Limitations

There are several limitations to this study which should be taken into account. The limited sample size is the first of its limitations. Since this is a non-representative study, the findings cannot be generalized and may not be applicable to the larger community of older individuals using healthcare systems. The varied range of perspectives and experiences may not be adequately represented by the experiences of these older adults.

The emphasis placed on self-reporting is a further limitation. The study relies on the self-reported experiences of participants because it uses a qualitative methodology. Self-reporting, however, can be vulnerable to recollection bias, social desirability bias, or individual interpretation, all of which could alter the veracity and accuracy of the

experiences of paternalistic behavior that people describe. Moreover, we acknowledge that the use of open-ended questions, while intended to minimize bias, may still have influenced participant responses. Additionally, the recruitment process and question framing might have influenced the way participants understood and discussed paternalistic behavior.

This study also lacks longitudinal data. Without considering potential changes over time or the long-term implications of paternalistic conduct on older individuals' mental health, it offers a snapshot of participants' experiences at a particular point in time. A deeper understanding of the temporal elements and potential variations in experiences and mental health outcomes would come from longitudinal data. Moreover, social and cultural factors may have an influence on this study's findings. Distinct cultural backgrounds, healthcare systems, and societal conventions may all have distinct impacts on paternalistic behavior and how it affects mental health. To prevent overgeneralizing the results, it is crucial to recognize these possible impacts.

Moreover, data on the specific type of ward (e.g., cardiac, oncology) in the healthcare settings attended by these participants were not available in our study. Additionally, we did not explore differences in experiences between genders, which might have offered additional insights into the complexity of paternalistic care. Future studies can include more detailed information about the healthcare context of each older participant.

Finally, this study's main focus is on the connection between paternalistic behavior and results related to mental health. However, several other elements, including socioeconomic position, social support, and individual resiliency, have an impact on the mental health of older persons. This study may have missed the complex interaction of these elements and their potential confounding effects on mental health outcomes by concentrating only on paternalistic conduct. Additionally, it is critical to take these limitations into account when interpreting these findings. To gain a deeper knowledge of paternalistic care behavior in health contexts and its effects on older individuals' mental health, additional research is necessary.

There are a number of implications from this relevant study, which can guide healthcare practice and policy. First, these findings highlight the need for better healthcare professional training programs. Training should emphasize the development of patient-centered and collaborative care strategies, ensuring that healthcare professionals have the knowledge and abilities to refrain from paternalistic actions that could have a detrimental effect on older individuals' mental health. Moreover, this study emphasizes the significance of developing policies and guidelines for healthcare systems that promote a sense of agency and autonomy among older adults. A framework that encourages courteous and empowered interactions between healthcare professionals and senior citizens can be established through policy, encouraging patient autonomy, and team decision-making. For healthcare workers to manage circumstances where paternalistic conduct may manifest, guidelines can offer specific guidance.

This study also points to the need for individualized approaches. To develop interventions that specifically address the mental health issues brought on by such encounters, it is important to comprehend the experiences of older persons who are the target of paternalistic conduct. Indeed, these findings showed the significant influence that paternalistic behaviors have on older adults' mental health, and emphasize the value of clear communication and patient education. Individualized interventions can play a crucial role in this regard, encouraging patients to engage in better communication with healthcare providers and remain focused on their treatment (Carpenter-Song et al. 2022). By addressing each patient's unique needs and preferences, healthcare professionals can foster a more collaborative and respectful relationship, ultimately improving mental health outcomes for older adults (Carpenter-Song et al. 2022). To promote collaborative decision-making and lessen the risk of paternalistic conduct, healthcare personnel should improve their communication skills, including active listening and clearly outlining treatment alternatives. By educating older adults about their rights, available treatments, and ways to advocate for themselves, patient education programs can help them feel more empowered.

Our study uniquely contributes to the existing body of knowledge by examining the impact of paternalistic behavior on older adults' mental health across diverse cultural contexts. We reveal how cultural differences influence the manifestation and perception of paternalistic care, offering nuanced insights into how these behaviors affect mental well-being in old age.

This study also proposes a number of alternatives for future directions. The long-term impact of paternalistic conduct on the mental health of older persons might be explored in more detail, taking other psychological and environmental aspects into account. Additionally, future studies may explore how paternalistic care behaviors may vary based on gender or age dynamics and their implications for healthcare practice. We also suggest the development of targeted questions based on identified themes (e.g., uniqueness of older adults) to explore participants' experiences in greater depth.

Moreover, these findings showed important differences between nationalities. Interestingly, even with different paternalistic experiences, all the older participants mostly felt anxious and stressed. Our understanding of how paternalistic conduct affects mental health outcomes in older persons can be deepened by more comparative studies across various cultural contexts, which will aid in the creation of effective and culturally relevant therapies. By considering these implications, healthcare professionals, politicians, and academics can collaborate to develop a healthcare system that puts a premium on person-centered treatment, respects older individuals' autonomy, and encourages good mental health outcomes.

In conclusion, the purpose of this study was to explore how paternalistic conduct affects the mental health of older persons when it occurs in the setting of health services. Several significant findings came to light through qualitative research, illuminating the complex link between paternalistic caregiving practice and older individuals' mental health. For the first objective, this study revealed that older adults mostly reported feeling a lack of attention to their uniqueness as individuals within the healthcare system. They expressed experiencing a duality of support and suppression of their independence, often encountering situations where their autonomy was disregarded.

Additionally, they received selective disclosure of information to keep the person's spirit up, as it compromised their understanding and decision-making process. The findings further indicated that some older adults felt neglected, facing opposition to their requests and having routine actions imposed upon them, without considering their individual needs and preferences.

For the second objective, this study highlighted the negative impact of paternalistic behavior on older adults' mental health. Participants reported feeling anxious and stressed due to the perceived loss of control over their healthcare decisions. They also expressed feelings of frustration, despair, injustice, and anger stemming from the disregard of their perspectives and preferences and the resulting lack of agency.

This study offers important new insights into how older people perceive paternalistic caregiving behavior in healthcare settings and how it affects their mental health. The results show that healthcare providers must adopt patient-centered strategies that value uniqueness, independence, and good communication. It is imperative that organizations and governments create rules and regulations that support patient-centered care, discourage paternalism, and encourage collaborative decision-making. Healthcare stakeholders can collaborate to create an atmosphere that respects older individuals' rights and dignity by resolving the challenges mentioned in this study, which will lead to better mental health outcomes.

In conclusion, this study urges a transition to person-centered care models that empower senior citizens, increase their agency in healthcare decisions, and advance their general well-being. In addition, programs for support and interventions should be created to address the effects of paternalistic care on older individuals' mental health. These programs can emphasize the development of coping skills, resilience, and self-advocacy while also giving older people a safe place to voice their worries and feelings. Finally, this

study clarifies older individuals' experiences with paternalistic caregiving in healthcare settings and its consequent effects on their mental health. We may work to establish a more patient-centered and empowered environment for older persons by resolving the highlighted difficulties and incorporating this study's findings into healthcare practice, thereby boosting their mental well-being and overall quality of care.

Author Contributions: Conceptualization, S.v.H.; methodology, S.v.H.; software, S.v.H.; validation, S.v.H. and S.S.; formal analysis, S.v.H.; investigation, S.v.H.; resources, S.v.H. and S.S.; data curation, S.v.H.; writing—original draft preparation, S.v.H. and S.S.; writing—review and editing, S.v.H.; visualization, S.v.H. and I.L.; supervision, S.v.H. and I.L.; project administration, S.v.H.; funding acquisition, S.v.H. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by the FCT—Fundação para a Ciência e Tecnologia, I.P., under Grant [number SFRH/BPD/116114/2016]. This work was funded with national funds from FCT—Fundação para a Ciência e Tecnologia, I.P., in the context of the project UID/04810/2020, DOI: 10.54499/UIDB/04810/2020.

Institutional Review Board Statement: The study was conducted according to the guidelines of the Declaration of Helsinki, and approved by the Ethics Committee of ISPA—Instituto Universitário (Protocol code: SFRH/BPD/116114/2016; Date of approval: 11 July 2016).

Informed Consent Statement: Informed consent was obtained from all subjects involved in this study.

Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available due to privacy and ethical restrictions.

Conflicts of Interest: The authors declare no conflicts of interest. The authors alone are responsible for the content and writing of this paper.

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