

How do family pressure, health and ambivalence factor into entering alcohol treatment? Experiences of people aged 60 and older with alcohol use disorder

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Abstract

Aim: This qualitative study is concerned with the motivations that lead older adults to enter treatment for alcohol problems. There is a need to expand our understanding of the unique characteristics and problems of this population to be able to devise specialised and effective treatments and preventive measures. **Method:** We conducted an analysis of secondary findings from interview data collected in a qualitative interpretative phenomenological analysis (IPA) study. Our participants were 12 elderly people aged 60 years or more who had experienced late-onset alcohol use disorder. Transcription, categorisation, collapsing and analysis were conducted rigorously in accordance with the IPA standards. **Findings:** Family can function as a pressure structure in terms of fostering motivation for treatment.

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Participants were to a certain extent ambivalent about treatment, which led them to devaluing treatment and its effects. Our results are on par with comparable results from other studies. **Conclusion:** Older adults who experience very-late-onset of alcohol use disorder experience familial pressure and health concerns which lead them to enter treatment. Our participants seemed ambivalent about treatment and its necessity, which seems to lead to a devaluation of therapy.

Keywords

agency, alcohol, alcohol use disorder, elderly, interviews, phenomenology, qualitative, treatment

A large majority (85%) of individuals with alcohol use disorders never seek any treatment for their alcohol-related problems (Grosso et al., 2013). People in the age group 65+ who have had either a substance use disorder or a mental health problem within the last year seem even less likely to report a perceived need for treatment or to actually seek treatment than people in younger age groups (Choi, DiNitto, & Marti, 2014). It has been suggested that people in the 60+ age group seek treatment for alcohol problems only when their misuse has caused extensive health or social problems (Jakobsson, Hensing, & Spak, 2005).

As has been found by several studies, the number of older adults is increasing and is predicted to continue to do so in the coming decades. As the number of older adults is predictive of the amount of older adults with alcohol use disorders, it is expected that the number of older adults with alcohol problems will increase accordingly (Bjork, Vinther-Larsen, & Thygesen, 2006; Blazer & Wu, 2009; Emiliussen, Nielsen, & Andersen, 2016; Hvidtfeldt, Vinther-Larsen, Bjork, Thygesen, & Grønbaek, 2006a, 2006b). This is already evident in Denmark. A study from 2006 found that from 1987 to 2003, the proportion of heavy alcohol users among males aged 50+ increased from 13.2% to 20.4% (Bjork et al., 2006). Given that very few people over 60 seek treatment for alcohol problems, and as the number of older people with alcohol problems is increasing, it is critical

that we find ways to engage these people in treatment.

One subgroup of particular interest in this regard is older adults with very-late-onset alcohol use disorder (VLO AUD). This group makes up a large section of all older adults with AUD. As many as 11–16% of all older adults experiencing alcohol problems experience VLO AUD (Adams & Waskel, 1991; Wetterling, Veltrup, John, & Driessen, 2003). The people experiencing VLO AUD have special characteristics, which makes it important to study them separately. They have higher levels of education, income and life satisfaction than individuals who experience earlier onset (Schonfeld & Dupree, 1991; Wetterling et al., 2003). Although drinking heavily, people in this group are less frequently diagnosed with alcohol dependence. They have significant differences in their preoccupation with drinking and a different capacity for controlling drinking behaviour when compared to individuals experiencing AUD onset before the age of 60 years (Wetterling et al., 2003).

In general very little research has been done on this subgroup (Atkinson, Tolson, & Turner, 1990; Emiliussen et al., 2016; Fink, Hays, Moore, & Beck, 1996; Wetterling et al., 2003). To be able to develop effective preventive measures and treatment for this specific subgroup, further investigation is vital (Bailis, Segall, & Chipperfield, 2010; Schonfeld & Dupree, 1991; Share, McCrady, & Epstein, 2004; Wetterling et al., 2003).

Is alcohol a problem in Denmark?

Traditionally, Danish alcohol research has been directed towards young people. However, this focus has shifted after it was discovered that in the normal population of 75 year olds in a medium-sized Danish city in 1989–1990, 33% of men and 19% of women drank alcohol on a daily basis. This is more than in Norway, Sweden and Finland. Additionally, the 75 year olds in that study did not think they had a problem with overconsumption of alcohol (Bjork et al., 2006; Pedersen, Rothenberg, & Maria, 2002).

When compared to other OECD countries, Denmark falls in the middle third as number 17 of the 34 countries included in the OECD *Health at a glance* report on alcohol consumption (OECD, 2015). According to the OECD (2014), Danes used 9.3 litres of pure alcohol on average per capita, which is more than in, for example, Spain, Belgium, Finland and Sweden.

In 2005 it was estimated that 620,000 Danes engaged in harmful use, and about 147,000 were alcohol dependent. Approximately 15,000 of the 147,000 are socially excluded, have mental problems and alcohol problems. Those seeking treatment are mainly men (68%) and are on average 45 years old (20 to 80 years), their alcohol problem has been ongoing for about 10 years before seeking treatment and amounts to around 20 standard units a day upon entering treatment. In 2013, only 15,420 Danes were in public treatment for alcohol problems. In 2013 it was estimated that 29.5% of adult Danes drank more than five units of alcohol on one occasion once a month (Becker, 2016), which constitutes binge drinking.

In Denmark, alcohol is an integral part of social life. Alcohol use over the last 30–35 years has been consistently very high, and Denmark has a liberal alcohol policy. Since the 1980s, there has been an increased focus on alcohol in relation to health policies: alcohol is viewed as a lifestyle health factor on par with smoking, diet and physical activity. However, Danes are less interested in changing alcohol-

related behaviour than behaviour related to these other factors (Elmeland, 2015).

From a qualitative investigation (Elmeland, 2015; Elmeland & Villumsen, 2013), it would appear that Danish alcohol consumption is regulated by social norms and rules rather than by health policies. Breaking these rules may lead to social exclusion and stigmatisation. As alcohol is such an integral part of everyday life in Denmark, the decision to stop drinking and to enter treatment for alcohol dependence may be a difficult one for the individual. Hence, it is crucial to shed more light on alcohol problems and the question of how to motivate all those who need it to enter treatment. Given that an under-recognised group of elderly alcohol-dependent individuals is now seeking professional help, it is particularly important to investigate what motivates them to seek treatment for their alcohol problems.

It seems that alcohol use in Denmark, compared to other Nordic countries, is rather high. Moreover it seems that older adults tend to underestimate the amount of alcohol they drink. This and the fact that relatively few people over the age of 60 enter treatment for alcohol problems means that an increased focus is needed on age groups other than the young.

Factors leading to alcohol use disorders

There is a clear link between certain socio-economic factors and alcohol use, including educational level, employment status, etc. It is nevertheless hard to determine causality (Becker, 2016). People can gravitate towards alcohol, drugs and tobacco because they are in trouble economically and socially, but it is probably not a simple correlation between social factors and alcohol use that explains alcohol problems in general. The causality probably goes both ways. Alcohol problems can lead to social problems and vice versa. However, the use of alcohol in difficult situations only seems to worsen the factors that lead to using alcohol in the first place (Becker, 2016; Nielsen, 2016).

General theories on motivation

As already pointed out, few older adults actively seek treatment. But how are we to define motivation and what can the treatment-seeking process look like? We use the term motivation as defined by Ryan and Deci (2000). They argue that to be motivated is to be moved to do *something*. Further, they distinguish between intrinsic and extrinsic motivation. This should not be understood as a distinction between “inner” and “outer” motivation, as intrinsic motivation exists only partly within the individual; more accurately, it exists between the individual and a given activity. Intrinsic motivation is catalysed (rather than caused) when individuals are in settings that lead them towards a given behaviour. However, most activities that individuals perform are not intrinsically motivating; they are performed because of social demands and roles, which are termed extrinsic motivation. If an individual responds to social demands and follows social roles, it is probably because it is important for him/her to feel respected and cared about by a significant other, which is an extrinsic motivation.

In a grounded theory study, Jakobsson et al. (2005) developed a model that described the process of going into treatment. They found that the basic process leading to treatment-seeking rests on a personal willingness to change one's life, the presence of demanding and caring support, the actuating of inner forces by existential dilemmas, having to deal with conflicting feelings and thoughts, being in or out of control, and the ability to manage identity and to react appropriately to pressure. If the participant was influenced by pressure from a social network, it was grounded in the closeness/significance of those exerting the pressure.

Another model of entering treatment that has won acclaim is the “stages of change” model first suggested by Prochaska and Di Clemente (1982). This is a pedagogical model that describes an “ideal” process of entering

treatment with six stages in its present state: pre-contemplation, contemplation, preparation, action, maintenance and relapse. These stages describe the process of entering, being in and ultimately leaving treatment. The stages that we are mainly interested in here are the first three, as we are concerned with investigating motivations for entering treatment.

Orford et al. (2006) developed another model to illuminate client perspectives on change in relation to treatment based on qualitative data from a grounded theory design in the UK Alcohol Treatment Trial. They suggested a model of change with categories affected by treatment: thinking differently, family and friends' support, and acting differently. They found that the family could exercise control over the clients' drinking, offer support and be available to the participants. The family hence exerts positive control over the participants in the recovery process. However, they also found that participants would describe how change was “down to me” and not necessarily a result of treatment or family support. The participants thus explained that change was self-directed and only parts of treatment were necessary.

Aim

The aim of our study is to explore how 60+-year-old patients with VLO AUD who have entered into treatment for alcohol problems describe their experience leading up to treatment-seeking and how they make sense of treatment as part of their recovery. We were specifically interested in what motivated participants to seek treatment as so few older adults actually do this.

Method

Participants

We contacted 29 people for this study. Of these 29, our final group of participants consisted of

Table 1. Demographic details of participants.

Alias	Age at interview	Age at first treatment	Sex	Early retirement	Previous employment	Other psychiatric treat	Sessions
Alfred	61	60	Male	Yes	Salesman	No	4
Clara	71	70	Female	Yes	Office worker	No	12
Ditlev	76	75	Male	Yes	Deliveries	No	<4
Esther	70	69	Female	Yes	Social worker	Yes	12
Flora	70	69	Female	Yes	Seamstress	No	12
Gunner	68	67	Male	Yes	Teacher	Yes	4
Herbert	68	65	Male	Yes	Teacher	No	<4
Judith	68	67	Female	Yes	Healthcare worker	Yes	12
Kurt	67	66	Male	Yes	Academic	No	12
Ludvig	70	63	Male	No	Healthcare worker	No	4
Martha	64	64	Female	N/A	Healthcare worker	No	<10
Oluf	70	69	Male	No	Municipal worker	No	<4

12 Danish people: 7 men and 5 women (see Table 1). At the time of the interview they had all been sober for at least two weeks and were at different stages of their treatment. Some were just finishing their treatment, and one had been out of treatment for a year. Three participants had been in psychiatric/psychological treatment previously for problems unrelated to their alcohol problem. The remaining 9 had never been in treatment before. All participants had some level of formal education, and 9 participants had retired early.

Bracketing

Bracketing is an analytical approach where the researcher tries to put aside his/her taken-for-granted familiarity with a given phenomenon, to focus on the perception of the world instead of reproduction. In this study bracketing was achieved by a thorough and methodical investigation of the field of VLO AUD in a systematic review (Emiliussen et al., 2016). Further, the authors discussed the taboos around AUD and the difficulties of interviewing people with alcohol problems, debated the trustworthiness of alcohol abuser testimonies and the intrinsic problems of interviewing in general. These discussions lead to the reservations mentioned in the description of the interview guide below.

Interview guide

Our interview guide was piloted on three separate pilot participants, of whom one was eventually included in the sample for our study (Alfred). These interviews were followed up by questions about the interview guide and the interview experience, where the participants suggested revisions to the interview guide and the style of the interview. Based on this input, we subsequently made minor revisions to the interview guide (final version available from the first author upon request).

The interview guide allowed participants free expression of opinion and experiences while ensuring that they stayed to the point. We phrased the questions with reference to the individual participants' experiences of a given phenomenon and sought to make the questions non-leading and open ended. The interview guide was constructed to avoid any presuppositions, which we achieved by referring back to our bracketing discussion. We constructed the guide with the intention to ease the participants towards the more emotionally loaded questions. We used the same interview guide for all the ensuing interviews to avoid discrepancies between interviews that might render the results incomparable.

Inclusion criteria

The participants were recruited from the Danish Elderly Study (Andersen et al., 2015; Søgaard Nielsen et al., 2016). The Elderly Study is a randomised controlled clinical trial conducted in the three major Danish cities of Copenhagen, Aarhus and Odense and in similar sites in Germany and the USA. Participants for this study were individuals who had actively sought treatment. Other inclusion criteria in the Elderly Study were: not suffering from psychosis, severe depression, bipolar disorder or suicidal behaviour. In the Elderly Study the participants were included consecutively and assessed by a battery of questionnaires. The answers were monitored by gatekeepers in the Elderly Study. The gatekeeper would hand out a pamphlet to potential participants with information on the present study and encourage the participant to contact us. We also posted a letter with information on the study to potential participants. After two to three weeks we would contact the potential participants by phone and ask them to participate.

Consent

All participants were informed verbally and in writing about the study and gave their written consent to study participation. All participants were given an alias when the interviews were transcribed to ensure anonymity. Therefore, the names given in Table 1 and throughout this article are aliases and not real names. The study was processed by the Danish National Research Ethics Committee on 3 July 2014.

Interviews

Between July 2014 and May 2016 in Aarhus, Odense and Copenhagen, all participants in the Elderly Study who reported that their abuse had commenced after the age of 60 were invited to participate in the present study. Those who accepted were interviewed by the lead author of this article for 45 to 60 minutes.

Six of the interviews were conducted in an interview room at the alcohol treatment centre where the participant usually received his/her treatment sessions in the Elderly Study. The remaining six interviews were conducted in the participants' homes. Before the interview the interviewer would engage in small talk with the participants to establish rapport. The interviewer presented himself in a neutral, professional manner and underlined that there were no right or wrong answers. The interviewer tried to keep intervention to a minimum and to let topics run, even if they digressed.

Data saturation

At participant number nine we saw significant repeats of content in the interview. At interviews 11 and 12 we found no new categories in the transcription. We therefore consider that data saturation was achieved.

Transcription and translation

The interviews were transcribed by the person who had conducted the interviews. The interviews were transcribed and processed in the original language. The quotes presented in this report were translated in cooperation between the authors and a professional interpreter/proofreader native in the English language.

Data analysis

We utilised semi-structured interviews in order to qualitatively investigate the participants' perspectives on their treatment and their motivation to enter treatment, with as little influence from the interviewer as possible (Tanggaard & Brinkmann, 2010). We employed interpretative phenomenological analysis (IPA) as we wanted as rich and comprehensive a description of the subjective experience as possible. This method of investigation is grounded in phenomenological, hermeneutical and ideographic traditions (for

further information see Smith, 2010; Smith & Eatoun, 2007; Smith, Flowers, & Larkin, 2009; Smith & Osborn, 2008). The analysis procedure consists of six steps which we have followed rigorously. In step one, we read and re-read the transcripts to emerge ourselves in the data. In step two, we started noting anything and everything that seemed interesting to our investigation. In step three, we created emergent themes based on our notes and readings. In step four, we mapped out the connections between themes. In step five, we moved on to the next case, and in the last step, we identified patterns across the interviews.

Findings

In the analysis we identified 18 superordinate categories across cases of which we will focus on four here: family, treatment, self-reliance/maintaining agency and finding motivations to quit. Other main findings will be reported elsewhere (see Emiliussen, Andersen, & Nielsen, in press).

Family as pressure structure

Most of our participants recounted that their families had been involved in their decision to start therapy. Often our participants described a discrepancy between how they themselves experienced their alcohol use and what their family experienced. Alfred elaborates:

I: [...] what made you decide that you needed treatment?

A: I do so because [...] for a start, I can see that I'm drinking too much. [I: Yes] I realise that I have a problem, and I also realise that I might not be able to sort out this problem by myself [...]. And my wife thought that I had a serious problem. [I: Mm]. And so, yeah, we started looking at what we might do [...] and we took the decision to drive over [here] [...]. (Alfred, l. 520–526)

Alfred describes the situation in low-key terms, saying that he could see that he drank too much.

By contrast, he quotes his wife defining the problem as “a serious problem”. Interestingly, at the end of the extract, Alfred says “and we took the decision to drive over [here]”. The change from using the pronouns “me” and “she” to using “we” indicates that the decision to seek treatment was not Alfred's own, but in part his wife's. Later in the interview, Alfred hints that his wife gave him an ultimatum about going into treatment, which would also indicate that the decision was not entirely his own. Alfred's situation has some similarities with that of Esther as described in the following extract. However, there seems to be a different emphasis on the element of personal motivation to start treatment.

E: [...] I could also choose to continue [...] drinking, and then it would [...] slowly be the end of me [...]. Maybe losing my family too [I: Yes], it's no joke [I: No, no, no], having a wife who drinks [...].

I: [...] so three years ago, you said.

E: I like, took stock, talking to my husband about it too, and we agreed that now some sort of treatment was called for. (Esther, l. 44–55)

At the beginning of the extract, we sense how Esther has her own personal motivations for going into treatment. However, in the very last part of the extract, the statement about taking stock and agreeing with her husband on going into treatment puts Esther's motivations in an entirely new light. This statement is repeated later in the interview (l. 377–388), illustrating that Esther's motivations are not purely intrinsic.

Similarly Clara describes the point at which she made the decision to go into treatment:

C: [...] I went there with my daughter [...], it was a Thursday and I hadn't been drinking since Tuesday noon, and then we talked to [the doctor ed.] [...] and he says, [...] please blow into this [Alcometer] and so I did, and then he said, well, you can have Antabuse right away. And my daughter was sitting next to me and I thought

“What?!” [laughs] and then I said, well, OK, I’ll do it [...]. (Clara, l. 7–12)

The pressure Clara describes seems similar to that hinted at in Alfred’s description. By saying: “And my daughter was sitting next to me and I thought ‘What?!’ [laughs] and then I said, well, OK, I’ll do it”, she refers both to her own initial resistance and to the impact of family pressure. Clara brings out the nature of the experience by mentioning that her daughter is sitting beside her and how she herself is thinking “What?!” Maybe she is indicating how at that time she thought that going into treatment was a step too far, while experiencing her daughter’s presence as upping the pressure to seek treatment. However, her little exclamation may also be an indication of how it suddenly dawned on Clara that she had a problem with alcohol. Either way, Clara demonstrates how social pressure from a family member was experienced before entering treatment.

Family pressure may also take a more organised form as explained by Ditlev:

I: [...] when did you notice that it had become a problem? [...]

D: Uhm, I realised [...] it [...] when [my partner] says so [...] and she has a [...] talk with the kids [...] without me around [...], and they talk [...] about it [I: Yes], and they agree that [...] the boys will have a chat with me [I: Okay]. And [...] they come to me and say [...] we can’t just watch you heading for a breakdown like this [I: No] when you’ve always been sober, and we’ve been proud of your life [...] and I agree to go to [I: To go down to the [alcohol treatment centre]] [...] so [...] they have really backed me up in this [...]

I: And that has been important.

D: Yes, it has [I: Yes], because [...] it’s a bit ... well, when your sons are sitting there and telling you that you’re turning into a drunkard and stuff like that, right [...] it bites at something inside you [...]. (Ditlev, l. 208–225)

Ditlev realises that he has a problem and also realises that his spouse and children care about

him, which in the end serves as a motivation for seeking treatment.

Kurt explains that it was his relationship with his grandson that motivated him to stop drinking and enter treatment. Kurt highlights the importance of seeing oneself as a resourceful and loved grandparent as a motivating factor in the longer term, rather than family members and doctors trying to reason with him. In Kurt’s account, the latter did, however, motivate in the short term.

K: ... [...] and I did also go to the doctor’s [...] and we had [...] a group meeting ... where [...] I was told in very plain language what they thought about my behaviour. And then I said: “OK, I’m quitting now” [...] And I did, until Christmas [...] and [...] I started [drinking] again [...] and I had help from a psychologist [...] and [...] talked to my doctor regularly [...] and I talked to my family regularly [...] then they said – like my ex-wife [...]: “This is going to kill you” [...] and “you’re a grandfather now ... and, he [the grandson] doesn’t know what you get up to ... but he’ll begin to withdraw from you, because he can sense something strange about you and that there’s something wrong” [...]. (Kurt, l. 138–145)

On the face of it, Kurt seems fairly unfazed by the fact that his drinking habits have the potential to kill him. However, upon realising that his grandson may begin to avoid him if he is drunk all the time, entering treatment becomes important. This is an account of both the emotional and pragmatic pressures that are being exerted on Kurt.

In the previous extracts, we have seen how our participants find that family can be a key factor in their decision to enter treatment. This benign pressure takes different forms and some of it is not always intentional or explicit. In the cases under consideration here, it seems that being “a supportive family” is the most common theme. “The supportive family” can be seen as a pressure structure that leaves the individual with alcohol problems little choice but to

enter treatment, even if he/she does not think of him/herself as having a problem with alcohol.

Health as motivation to enter treatment

Nearly half our participants stated that their physical health was one of the key motivators in entering treatment. When relating alcohol problems to physical problems, however, it suddenly becomes an existential topic more than a purely motivational one. The individual not only seems motivated to enter treatment, but realises the fragility of life in late age. It is these kinds of concerns that are to the fore in the following extracts.

E: [...] Well [...] physically you don't tolerate alcohol as well when you get older [...].

I: Was that a consideration [...] in relation to seeking treatment?

E: It was [...]. Definitely... If not, your blood pressure goes up and you risk higher liver enzyme levels [...] and stuff like that, right. [...] It's not exactly something that makes the situation any better [...] So, it was part of it [...]. (Esther, l. 150–156)

Esther seems to be somewhat ironic about it as she remarks “it's not exactly something that makes the situation any better”. This nonchalance is likely a reaction to the sudden realisation that the consequences of alcohol may be severely detrimental to her health. Instead of taking it in Esther dismisses it with a humorous comment. Moreover the phrase “and stuff like that, right” also serves to diminish the emotional impact of the realisation. But it is probably the realisation of one's own frailty which helps her make the change.

In Flora's case we find this confrontation as well:

F: [...] It is because I went to hospital [...]. And I had a blood clot [in the head] [...]. So [my friend] she drove me straight to A&E [...] and [...] I had a scan and all that [...] Then they said that they couldn't see anything [...], but at my own doctor's, they could see that I'd had a

blood clot in the speech centre in my head [...]. And that is why they advised me not to drink. (Flora, l. 136–146)

In Flora's case, the motivation to stop drinking may be grounded in her own health concerns, but is increased by external factors: the acute disease. Then the motivation for someone to stop drinking may be due to health concerns, but not necessarily on an intrinsic level. The motivation may be activated by the GP as much as it is grounded in Flora's own insight into her medical condition. This tendency was obvious in Kurt's case as well.

What we have found is that abrupt health-related events can prompt an individual to seek treatment. Hence, we find that in older adults, treatment may be motivated not by a general, ongoing concern about health but rather by specific incidents.

Ambivalence about treatment

Some of our participants show an interesting oscillation between valuation and devaluation of therapy. First, we turn to Alfred:

A: [...] When I [...] look at the treatment I've received, I am, of course, very grateful to have had that treatment [...] but [...] it's not just the treatment that results in – bang – I'm clean [I: No]. No way. [...] but it's given me some tools, it's given me something to talk about [...] it has given [...] some [...] good things uhm to keep on working with [I: Yes] and [...] it's meant [...] a bit, especially to my wife [...] that I did this, and [...] to the people who are closest to me [...]. Feel that it was good that I did this. And it was, no question about it, but I just believe that I could have got out of it anyway on my own. Because my wife suddenly put her foot [...] down, that “you are going to stop this or it's the end of our marriage” [...] so I think that, I don't know [I: You could]. I could have stopped on my own. [I: Yes yes] I think so. (Alfred, l. 526–537)

Throughout the extract Alfred alternates between valuing and devaluing the treatment.

His account is a good example of how the valuing and devaluing proceeds: the participant begins by praising treatment, and then explains that it was not necessary, and then goes back to praising it again. In the end comes an unequivocal statement about how Alfred thinks he could have handled his problem without treatment. A variation of the same pattern is seen in Gunner's description:

G: [...] well [...] what is the point of the motivational interviewing [I: Yes] what are they aiming at [...] and [...] then I could imagine [...] in hindsight [...] [that] the aim was to prompt the decision to stop drinking, and then with some kind of treatment thrown in [...] for instance Antabuse to, like, support [I: Yes] your staying off drink, or something that reduces craving [...].

I: Or something further [G: Yes] therapy if you think that's the thing [G: Yes yes yes] [...] you think [...] the motivational [conversations] couldn't really stand alone? [G: Yes, I [...] I think that yes].

G: [...] therapy can be [...] so many things and [...] maybe it is good for some [I: Yes] and [...] I don't think it would be any good to me [I: No no no] well. [...] Or I don't know about "good", but, well, a little, a little uhm, bit of a waste of time [...]. (Gunner, l. 461–474)

Although he offers a critique of motivational interviewing, Gunner also endorses the treatment by suggesting that others could benefit from it. At the same time, Gunner devalues the treatment and calls it a "bit of a waste of time". In fact, he explicitly says that he did not benefit from it, as he did not need further motivation. In other words, Gunner's devaluation of treatment is based upon his sense of his own capacity to stay motivated. As with Alfred, we get an unequivocal statement about how treatment was superfluous to Gunner.

Lastly, we look at Ditlev, who is also talking about how he wants to handle the problem himself:

D: But it is not a problem today either [...]. Because I was in treatment at this centre [...]

and it was the idea that [...] they'd get other things [...] up and running for me, when I said that I think that I have so much self-control [...] that I want to see if I can handle it [...] by myself. (Ditlev, l. 139–143)

This may be one of the more clear-cut cases of actively regaining agency in a situation with only a few options. As we saw earlier, Ditlev was confronted by his family and he acquiesced to enter treatment. In the extract above, we find that Ditlev is regaining control and agency by quitting treatment and relying on his own self-discipline to get better.

In this section we have shown how our participants oscillate between valuation and devaluation of treatment. Simultaneously we have found a tendency in our participants to want to "take matters into their own hands" or assess that they could have managed without treatment. We can only speculate whether it is true that they could have done so, but we can identify this as a self-oriented experience of change. By devaluating the need for treatment and underlining that they could have managed or wanted to manage recovery themselves, they seem to regain a certain amount of agency. On a speculative note we might consider this a way of reacting to the familial pressure identified earlier. This valuation and devaluation may be both evidence of ambivalence in relation to treatment and a way for our participants to try and regain some control over the situation. This however, remains speculation.

Discussion

In our study, most of our participants had experienced that their family put some form of pressure on them to enter treatment. We also found that health plays a part in motivating people to enter treatment. Lastly we found that participants oscillated between valuation and devaluation of treatment perhaps as a sign of ambivalence brought on by a wish to take care of one's own problems.

If we view our findings along the lines of the stages of change model (Prochaska & Di Clemente, 1982), our participants seem to describe experiences taking place during the pre-contemplation and contemplation stages and perhaps even the preparation stages. Before our participants experienced family pressure, they were likely at the pre-contemplation stage and had not considered change because they did not perceive a problem. Family pressure is likely to have pushed them through the three first stages of the model. Having rushed through the first three stages of the model could also explain why our participants often engaged in a devaluation of therapy. They may not have had the time to contemplate what they could and would do on their own. Further, they may not have had time to consider what they wanted from treatment. Our findings suggest that this could lead to oscillating between valuation and devaluation, which may create a sense in older adults of being able to take care of the problem on their own. It may be necessary to consider this when engaging with people experiencing VLO AUD in clinical work, as they might benefit from a contemplative period before proceeding with treatment.

Our findings are comparable to those of Orford et al. (2006). We found similar categories both of the family as a supportive structure and the “down to me” tendency. The mean age of the participants in their investigation was 42 years, which seems to indicate that there is a certain overlap in experiences related to recovery in different age groups. However, Orford et al. (2006) did not describe family pressure as identified by us. We speculate that this could be a difference between the age groups, but further investigation is needed to confirm this.

Our findings on the family as a pressure structure are also consistent with the model suggested by Jakobsson et al. (2005). They stated that one of the extrinsic motivators to go into treatment could be the threat of one’s spouse leaving. Moreover, they found that social pressure coming from close or significant others was related to readiness for treatment. We

found that a spouse giving an ultimatum of leaving and even the perceived threat was experienced as extrinsic motivation for our participants. We speculate that older adults might experience these ultimatums as a more pronounced threat than would younger and middle-aged people. Older adults’ opportunities to gain new friendships or partners are limited (relatively to when they were younger) and hence they may place a higher value on family and spouses than they did earlier in life. Further, the realisation of the fragility of life in old age uncovered in our analysis may further augment the need for family and close relations.

Although there may be certain intrinsic motivations for older adults experiencing VLO AUD to seek treatment, we primarily met descriptions of more obvious extrinsic motivations, including the perceived pressure exerted by family. This finding is supported by Ryan and Deci (2000), who claim that individuals may be particularly willing to adopt behaviours that are valued by significant others, precisely as we have observed in our study. This may be a result of elderly people being more likely to value family and focus on others, whom they are accordingly more likely to try to please (Bailis et al., 2010; Hoogland, 2015). Hence the interplay between social pressure from the family and the older adults can be seen as an effort on the part of these older adults to indulge/yield to their family. This conclusion is also backed up by the investigations conducted by Steinberg, Epstein, McCrady, and Hirsch (1997), who found that most of their participants (53%) had been coerced by their spouses to begin treatment. This finding tallies with the general description of Danish alcohol culture and the fact that Danes are less willing to change their alcohol behaviour than other risk-heavy health behaviours (Elmeland, 2015). The reduced willingness to change suggests that stronger motivation is needed for change to occur. It therefore makes sense in the cultural environment in which our participants live that they are motivated by their spouses or families. We might hypothesise that those who

do not present for treatment have not encountered the same degree of pressure from their family, and have not experienced the same extrinsic motivations as those included in our study. Such an idea is consistent with the findings of Korcha, Polcin, Kerr, Greenfield, and Bond (2013), who found that (social) pressure to alter drinking behaviour is also associated with an increase in help-seeking behaviour. This underlines our earlier consideration on the lack of time for contemplation before entering treatment. We would suggest that individuals experiencing VLO AUD be offered time to contemplate the implications and purposes of treatment together with the therapist. We hypothesise that this might lessen the oscillation and ambivalence about treatment that we have identified.

Ryan and Deci (2000) suggest that supporting the needs for autonomy and competence can facilitate intrinsic motivation. This is why the discussion on maintaining agency is important. For the individual to feel intrinsically motivated, it is important to feel autonomous and competent. Moreover, the participants ascribe a lot of the effects of treatment to themselves, which also underlines how critical “competence” is. We were able to support the findings of Steinberg et al. (1997), who found that a large majority (90%) of their older adult participants cited external motivation for going into treatment. However, our findings show that the older adults experiencing VLO AUD often explain changes in the light of self-directed change. Seeking treatment may well be facilitated by, for example, family pressure, but older adults typically seek ways of regaining their agency. Older adult drinkers achieve this by taking charge of their recovery/health management. It was a consistent finding in our study that the older individuals always seemed to gravitate towards an internal explanation when describing change. The goal of the treatment methods utilised in the Elderly Study is to support the client’s sense of autonomy (Andersen et al., 2015). When participants offer their experience of therapy, it emerges as not being

beneficial in itself. In the participants’ accounts, it will appear as the treatment having failed to engage them in ways that enabled them to readily identify what the treatment gave them. This may, in our view, mostly be evidence of the trade-off between agency and social pressure. However, there may also be a problem on a pragmatic or informational level regarding the goals in treatment and what is done to achieve them.

We also found that health has some impact on elderly people’s motivation for seeking treatment. Hence, our study supports the findings of Jakobsson et al. (2005) and Korcha et al. (2013). We found that health may not be experienced as an intrinsic motivation to start treatment but rather as an extrinsic motivation.

Although others have found gender-specific motivations (Grosso et al., 2013; Share et al., 2004), we were not able to identify any differences in motivation between male and female participants.

Limitations

While it is a general ambition in phenomenological research to use a homogeneous group so as to ensure a certain level of cross-interview comparison and, to some extent, generalisation, the group in this study is perhaps particularly homogenous. Because we recruited our participants from the Elderly Study, they fulfilled all the criteria that were formulated for the Elderly Study. This already makes the group somewhat homogenous. Moreover, as participation in both the Elderly Study and our study was voluntary, these are people who are interested in participating in research. They are also people who have admitted to and sought treatment for an alcohol-related problem. All participants reported a positive outcome of treatment during the interviews (in spite of devaluation), which makes our participants a subgroup of those who have received treatment. Hence our participants may not be representative of the entire population of older adults experiencing VLO AUD.

In literature on entering treatment it is usual to discuss barriers to entering treatment. We have not engaged in such a discussion partly because our participants did not talk about the barriers, and partly because we have been interested in what motivates entering treatment, rather than the opposite.

Further, we have not engaged extensively in comparing our results with other age groups. Even though we have some evidence that the people experiencing VLO AUD have different characteristics than people who experience onset at other ages, we cannot say if our participants are different from or equal to all other age groups. This is surely a limitation of qualitative inquiry, and we would encourage any effort looking into age-related differences in entering alcohol treatment.

Lastly, our study is retrospective and can be prone to biases of memory and social desirability. Our study could be especially susceptible to memory biases as one of our participants had been out of treatment for up to a year. Moreover qualitative studies have a small sample size by definition and our results should be considered accordingly.

Conclusion

Older adults experiencing very-late-onset alcohol use disorders describe that their family, and their spouses in particular, put pressure on them to go into treatment. This seems to be one of the main motivations for them to go into treatment. However, once in treatment these older adult individuals engage in a process of valuing and devaluing treatment and its effects. We suggest incorporating these findings in clinical treatment of the subgroup of older adults with alcohol problems, as this offers a unique opportunity to further engage them in therapy.

Note

1. [...] denotes excision of material, usually of verbal noise, repeated sentences or interviewer echoes.

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