Mattering in older adults in service-assisted recovery processes from substance use problems: Conditions, experiences, and implications for action

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Abstract

Aim: Mattering is a fundamental human experience promoting crucial components to later-life recovery processes. Today, the largest population of older adults persons with substance use problems, so far, is on a steep rise in many Western countries. To tailor and offer substance use services promoting mattering, more knowledge about later life mattering of older adults recovering with the assistance of substance use services is needed. This study aims to explore conditions for, and experiences of, mattering in older adults in service-assisted recovery from substance use problems.

Methods: A collaborative and deductive reflexive thematic approach was applied in analysing 23 interviews with participants using substance use services in their recovery processes from different substance use problems: alcohol, medication and illegal substances. The participants were recruited from three different Norwegian contexts: two urban and one medium size municipality. The age of the sample ranged from 65-80 years, with approximately equal numbers for those aged 60-69 (12 participants) and 70-80 (11 participants). Seven participants were women and 16 men.

Results: Two main themes were identified in the data: "Conditions for later life mattering" and "Experiences of mattering from community relationships and own actions". The findings illustrate various conditions of mattering and experiences of mattering and not mattering in later life recovery processes.

Conclusions: Several participants experienced not mattering; promoted by lack of support, disrespect and devaluation and loss of relationships, but also being ignored and not receiving fair treatment and help by service professionals. Overall, the participants' mattering depended on fair and healthy community relationships; fair distribution of resources such as affordable housing, accessible transportation, and fair organizational structures where participants could feel valued and also have a chance to add value to others. Several practical implications to enhance the therapeutic and preventive potentials of later life mattering in recovery are suggested.

Background

To thrive and have a good life, we all need to experience social worth, dignity, and respect, regardless of age, gender, race, ethnic identity, geographical location, socioeconomic or occupational status (1–3). Mattering is a fundamental human experience across the life span, often experienced in communities. Conceptually, mattering can be defined as a state where people "feel valued by, and add value to, self and others" (4). The experience of mattering is also highly correlated to positive psychological outcomes, including happiness (5), meaning (6), overall well-being (2, 7), workplace well-being (8), and life satisfaction (9, 10). A life lacking in mattering is associated with suicidal ideation and attempts (11–14), depression (15, 16), aggression (3, 17), loneliness (18) and overall stress (19) and usually takes place when we feel marginalized, excluded, devalued, and disrespected (2).

Despite increasing investigations of mattering and its relevance in promoting health in later life, older people have, until recently, been largely ignored in studies of mattering. In a recent review of mattering in old age, Flett and Heise (20) argue that mattering is a unique protective factor in the prevention of mental and physical problems among older adults. Their review also suggests that later life mattering can promote crucial components in recovery processes, such as the experience of belongingness and a meaningful life (20, 21). Older adults with substance use problems (defined as 65 year +) is a group on a steep rise in several Western societies (22–24). Consequently, there is a pressing need today for substance use services tailored for this group (24–26). More knowledge about later-life mattering from older adults in recovery processes assisted by substance use services is needed to tailor and offer services promoting mattering for the many older adults in recovery from substance use problems. Focusing on first-person accounts from older people using different substance use services to assist their recovery processes from substance use problems, we will explore conditions and experiences of mattering, as well as implications for action for substance use services.

Mattering and Substance Use in Later Life Recovery Processes

Mattering is about a balance between feeling valued and adding value, to self and others, throughout one's life (20, 27). Across different stages of life, however, conditions for this balance may change with shifts in the individual's social belonging and community memberships (28). Moreover, the domains where people experience being of value and/or adding value to others, may change across the lifespan. When life and life transitions are complicated by substance use problems, the struggle to achieve mattering may become even more difficult and complex. Older adults with substance use problems are often subjected to deteriorating health, comorbidity, high likelihood of depression, shame, loneliness and social isolation (26, 29–32). Such conditions can be crucial obstacles to mattering later in life, restricting both the experience of feeling valued as well as the possibility of adding value to self and others. Considering the unique protective and promoting psychological effects of later life mattering (e.g., self-esteem, social support, lower depression and greater psychosocial well-being and wellness) (20, 33), more knowledge about mattering among older adults with substance use problems is essential today. Specifically, there is need for knowledge about mattering from older adults in service-assisted recovery processes to enhance the therapeutic and preventive implications of mattering in substance use services.

Current study

This study aims to explore and understand conditions and experiences of mattering for older adults in service-assisted recovery processes from substance use problems. By a collaborative research approach including a community psychological, sociological and collaborative research point of reference (34–36), we assume that older adults recovering from substance use problems are social agents and experts on their own lived experiences. They understand best their conditions promoting and challenging experiences in their personal recovery processes. Furthermore, we have taken a reflexive, deductive thematic orientation (37–39), assuming that theoretical frameworks, also the framework of mattering (20, 27), can be used as a relevant theoretical lens to move beyond obvious meaning in the data, guiding, informing and deepening our collaborative analysis and interpretations of the participants' experiences.

We have analysed data from a national Norwegian qualitative study on service user experiences of older adults struggling with substance use problems and receiving municipal services for persons with substance use problems (see (40)). The data included 23 interviews with participants (7 women, 16 men) from
different Norwegian municipalities having different substance use problems: alcohol, medication and illegal substance use. 21 of 23 interviews included descriptions of feeling valued by or adding values to self and others. Guided by the participants' descriptions of mattering, we have explored older adults' experiences of feeling valued by, and adding value to, self and others during their service-assisted recovery processes.

**Methods**

**Sample and recruitment**

As presented, this study utilized data from a larger national project evaluating service users' experiences with substance use treatment services from Norwegian municipalities (see (40) for further details). The Drug and Alcohol Competence Centre in Central Norway conducted this study on assignment by the Norwegian Directorate of Health. The national project's second wave aimed to generate qualitative knowledge about how older adults with substance use problems experience the different substance use services offered from the Norwegian municipalities.

A purposeful sampling strategy was used in the study to recruit 23 older adult participants with substance use problems from three different contexts: two urban and one medium size municipality. The age of the sample ranged from 65-80 years, with approximately equal numbers for those aged 60-69 (12 participants) and 70-80 (11 participants). Seven participants were women and 16 men.

Different groups of service staff (e.g., geriatric psychologists, staff at user organizations, and substance use treatment clinics) working with older adults with substance use problems collaborated and assisted in the planning of participant recruitment in all three contexts in 2019 (prior to the Covid-19 pandemic). Staff contacted potential participants directly by phone and in physical meetings, as well as contacting services relevant for recruitment of additional participants (e.g., general practitioners, home nursing, low threshold services where no formal referral is required (e.g., the Salvation Army's social security and welfare services and contact centres helping with basic needs such as nutrition, clothing, and hygiene) and geriatric clinics in specialized health care). The services were contacted in physical meetings, and by email, phone, and newsletters inviting them to recruit participants.

All participants recruited had to meet the following criteria: age 65 years or older (which is consistent with definitions of old age in populations with substance use problems (Choi et al., 2014; LaBarre et al., 2021); as well as having a substance use problem with alcohol, medicine or illegal drugs and receiving assistance from one or several services from the municipality in which they resided. Overall, we had a heterogeneous sample of older adults recovering from substance use problems (see Table 1).

Table 1. Participants' background
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>M66</td>
<td>5</td>
<td>East</td>
<td>Housing, housing allowance, NAV, organized physical exercise, general practitioner, low threshold offer (meals)</td>
<td>No</td>
<td>Early</td>
<td>Employer made contact</td>
<td>Amphetamine/Alcohol (Polysubstance use)</td>
</tr>
<tr>
<td>M67</td>
<td>4</td>
<td>East</td>
<td>Housing, contractual early retirement pension scheme (AFP) in the public sector, earlier: three different institutions, home nursing.</td>
<td>No</td>
<td>Early</td>
<td>Injury/hospitalization</td>
<td>Opioids/Alcohol (Polysubstance use)</td>
</tr>
<tr>
<td>M77</td>
<td>5</td>
<td>East</td>
<td>NAV, disability pension,</td>
<td>Yes</td>
<td>Early</td>
<td>Lack of income</td>
<td>Alcohol</td>
</tr>
<tr>
<td>M71</td>
<td>2</td>
<td>West</td>
<td>Contractual early retirement pension scheme (AFP) in the public sector, general practitioner, earlier: institution, NAV Assistive Technology Centre, institution</td>
<td>No</td>
<td>Early</td>
<td>Self-initiated contact</td>
<td>Alcohol/sleeping pills (Polysubstance use)</td>
</tr>
<tr>
<td>F68</td>
<td>5</td>
<td>East</td>
<td>Housing, Specialized health care (somatic) after injury, AV, Work assistance allowance (AAP), transport service card, general practitioner, physiotherapy, Earlier: six institutions</td>
<td>No</td>
<td>Early</td>
<td>Suicide attempt/hospitalization</td>
<td>Alcohol/Morphine (Polysubstance use)</td>
</tr>
<tr>
<td>M68</td>
<td>2</td>
<td>West</td>
<td>NAV, Crisis centre for victims of violence and abuse from partner or family, contractual early retirement pension scheme (AFP) in the public sector, organized physical exercise, earlier: institution</td>
<td>No</td>
<td>Early</td>
<td>Violence in the home (partner)</td>
<td>Alcohol</td>
</tr>
<tr>
<td>M80</td>
<td>4</td>
<td>East</td>
<td>Housing, pension (not specified), outreach service, home nursing, earlier: institution</td>
<td>No</td>
<td>Early</td>
<td>Recommended by family to make contact</td>
<td>Alcohol</td>
</tr>
<tr>
<td>M77</td>
<td>1</td>
<td>Central</td>
<td>Pension (not specified), home nursing, housing, NAV Assistive Technology Centre, general practitioner, geriatric psychologist, Earlier: recovery centre, physiotherapy,</td>
<td>No</td>
<td>Late</td>
<td>Recommended by home nurses to make contact</td>
<td>Alcohol</td>
</tr>
<tr>
<td>M76</td>
<td>1</td>
<td>Central</td>
<td>Pension (not specified), home nursing, NAV Assistive Technology Centre, earlier: institution, general practitioner</td>
<td>Yes</td>
<td>Very late (after 60 years)</td>
<td>Recommended by home nurses to make contact</td>
<td>Alcohol</td>
</tr>
<tr>
<td>F65</td>
<td>1</td>
<td>Central</td>
<td>NAV, contractual early retirement pension scheme (AFP) in the public sector, earlier: organized physical exercise for chronic illness, follow-up service, centre for mapping and follow-up</td>
<td>No</td>
<td>Late</td>
<td>Chronic muscular pain lead to hospitalization</td>
<td>Alcohol</td>
</tr>
<tr>
<td>M68</td>
<td>1</td>
<td>Central</td>
<td>Pension (not specified), physiotherapy, home</td>
<td>No</td>
<td>Late</td>
<td>Friend assisted in making contact</td>
<td>Alcohol</td>
</tr>
<tr>
<td>ID</td>
<td>Age</td>
<td>Gender</td>
<td>Region</td>
<td>Service</td>
<td>Contracted</td>
<td>Contact Type</td>
<td>Drug(s)</td>
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<tr>
<td>F68</td>
<td>1</td>
<td>M</td>
<td>Central</td>
<td>Housing, contractual early retirement pension scheme (AFP) in the public sector, earlier: institution</td>
<td>No</td>
<td>Early</td>
<td>General practitioner made contact</td>
</tr>
<tr>
<td>F73</td>
<td>4</td>
<td>F</td>
<td>East</td>
<td>Pension (not specified), organized physical exercise, general practitioner, short-term specialized treatment of alcohol addiction, earlier: institution (twice), home nursing</td>
<td>Yes</td>
<td>Late (20 years)</td>
<td>Injury (fall)/hospitalization</td>
</tr>
<tr>
<td>M76</td>
<td>4</td>
<td>F</td>
<td>East</td>
<td>Pension (not specified), non-governmental organization for persons with alcohol dependence (Norske lenker), nursing home, physiotherapy, social worker, earlier: institution</td>
<td>No</td>
<td>Early</td>
<td>Injury (fall)/hospitalization</td>
</tr>
<tr>
<td>F66</td>
<td>4</td>
<td>M</td>
<td>East</td>
<td>Housing (municipality), psychologist, home nursing, disability benefits, drug-assisted treatment, interdisciplinary team meetings Flexible Assertive Community Treatment, NAV (economic manager), general practitioner, transport service card, earlier: institution psychiatric/substance use</td>
<td>No</td>
<td>Early: Medicine, Late: Heroin (40 years old)</td>
<td>Death of husband who was co-addict</td>
</tr>
<tr>
<td>M66</td>
<td>5</td>
<td>M</td>
<td>East</td>
<td>Housing, disability benefits, drug-assisted treatment, NAV, general practitioner, earlier: institutions</td>
<td>No (methadone)</td>
<td>Early</td>
<td>Personal contact at NAV made contact</td>
</tr>
<tr>
<td>M69 (E17)</td>
<td>5</td>
<td>M</td>
<td>East</td>
<td>Pension (not specified), NAV (management of economy), department of mental health, general practitioner, interdisciplinary team meetings home nursing, earlier: institution, cancer nurse,</td>
<td>No</td>
<td>Early (not specified, but had problems in working age)</td>
<td>Self-initiated contact with hospital due to suicide ideation</td>
</tr>
<tr>
<td>M69 (E18)</td>
<td>5</td>
<td>M</td>
<td>East</td>
<td>Housing, drug-assisted treatment, general practitioner, old-age pension, polyclinic treatment for persons with substance use problems where alcohol is the only or dominant problematic substance, low-threshold health and care offer for those with substance use problems, social worker, interdisciplinary team, earlier: psychologist, institution</td>
<td>No</td>
<td>Early</td>
<td>Quit work to become clean (self-sufficient), made contact due to starvation</td>
</tr>
<tr>
<td>M69 (C19)</td>
<td>1</td>
<td>M</td>
<td>Central</td>
<td>Housing, home nursing, social worker, centre for mapping and follow-up, district psychiatric centre, earlier: institutions</td>
<td>No</td>
<td>Early</td>
<td>Made contact due to suicide ideation</td>
</tr>
<tr>
<td>M70 (C20)</td>
<td>1</td>
<td>M</td>
<td>Central</td>
<td>Nursing home, pension (not specified), NAV (economic management),</td>
<td>No</td>
<td>Early</td>
<td>General practitioner referred to hospital (acute)</td>
</tr>
</tbody>
</table>
Data material

The data for the present study was a verbatim transcribed interview material. By a piloted interview guide (40) for further details, participants were asked about their life, of their background, current life situation, experiences with municipal services for persons with substance use problems, relationships with family members and significant others, and how others were involved in the services they received.

Substance use services and sociocultural context

The social and cultural context of this study was Norway, a Scandinavian welfare state. In the Norwegian public health care system, specialist health care services are offered at the regional level and primary health care services are organized and delivered by the municipalities. As part of Norwegian clinical substance use treatment, individuals are first offered primary services by the municipality prior to and after specialized treatment. Aside from an initial excess charge of NOK2460 per year (approximately USD285), all services are offered free of charge.

Generally, individualistic Northern counties have had less of a family orientation compared to Southern and Eastern European countries (41). There are studies indicating that family and friends are important social resources in later life recovery processes from substance use (42). However, given the welfare system and increasing individualistic orientation and meaning systems in the Norwegian context (43), there can be lower expectations of family support and higher expectations of support from services in the recovery processes than in more market-driven and familial and collectivistic contexts.

Approach to enquiry

This study applied a collaborative deductive and reflexive thematic approach. The collaborative approach defined the overall study and collaboration with persons who were experiencing, or had experienced, service-assisted recovery took place in all phases of the research project. First, a peer support worker from the Drug and Alcohol Competence Centre in Central Norway participated in the planning of the data collection, piloting and development of the semi-structured interview guide. Second, the data collection was a collaboration between the interviewers and 23 older adult participants holding different experiences of service-assisted recovery. Third, in the data analysis, a peer researcher (third author) collaborated with the first and second authors in the analysis to enhance reflexivity and interpretive depth. This peer researcher also had personal experience with service-assisted recovery, work experience with people in recovery from substance use, as well as research experience with qualitative collaborative research within the field of substance use and addiction.

With respect to dimensions for thematic analysis, the analysis was as presented deductive in its theoretical approach, epistemologically experiential, as well as constructivist in its perspective (37-39). To elaborate, the theoretical framework of mattering was used as a conceptual framework in coding and producing themes. A central experiential assumption, furthermore, was that that the participants’ descriptions mirrored their spoken experiences. Finally, the study is social constructivist as the multi-perspective analyses moves beyond the experienced phenomena of mattering to understand how mattering is socially constructed by community, relationships and services for persons with substance use problems.

Data analysis
The first approach was to undertake a coding of the material with mattering as the guiding perspective to look for: "experiences of feeling valued by, and adding value to, self and others" (4). The first author's coding showed that 21 of 23 interviews included descriptions of mattering and with a total of 216 coding references to mattering. The first author then invited the fourth and fifth author to undertake a collaborative and deductive thematic analysis of mattering. After accepted the invitation, the fourth author conducted his individual coding and generation of themes, while a peer researcher (fifth author) systematized potential patterns and insights about mattering, from the overall material. Thus, the analysis included several relevant perspectives: a community psychological, a sociological and a peer perspective, respectively. Next, the reviewing, defining, and naming of themes were carried out collaboratively through seven stages (see figure 1). The first author systematized and merged the researchers themes from stage three to six. Finally, in the seventh stage of the analysis all authors agreed on the final themes for the article. Consistent with the aim of the article, themes were narrowed down to and systematized with respect to conditions for and experiences of mattering in service-assisted recovery.

[1] Participants are represented with codes indicating their gender (F for female, M for male) and age.

[2] Interviewer 1 is the fourth author and an academic researcher; Interviewers 2 and 3 worked at The Drug and Alcohol Competence Centre in Central Norway, interviewers 4 and 5 worked at The Drug and Alcohol Competence Centre in Oslo. All interviewers had academic training in conducting interviews (5 of 5) and 3 of 5 had clinical competence in communication with individuals with substance use problems.

Results

Two main themes were generated from the analysis: “Conditions for later life mattering” and “Experiences of mattering from community relationships and own actions”. As can be seen in figure 1 (stage 2), there was a common experience for several of the participants of not mattering. Several participants seemed to have an experience of not being worthy of services or help, feeling strong guilt related to their life with substance use problems. This is an important finding that should not be underestimated. However, to gain needed knowledge for enhancing the therapeutic and preventive implications of mattering, we will focus on the conditions for, and experiences of mattering.

1. Conditions for later life mattering

Recovery and psychological sense of community as interrelated conditions for mattering

One of the overarching theme in the material, permeating all the other themes generated, suggested that recovery and psychological sense of community (PSOC) were central conditions to the participants mattering. In particular, the participants described the importance of relational sense of community:

When we (her friends and acquaintances from that place) get together. And people are taking a pint or a glass of wine. At that moment I miss it [drinking alcohol]. Luckily, when that thought strikes me, I think that “No. It's not going to be that way. You shouldn't have that [alcohol]”. And I appreciate that. That awareness. So that I can be with the people who make me feel that I belong.

As can be seen from this quote, recovery made relational communities and sources of mattering, available. Not only did the participant feel valued by friends, she also added value to self by appreciating her new strength in managing the substance use problem. This element of mattering empowered her recovery process, fuelling a reciprocal interaction between the three phenomena. There were similar examples in the material with respect to family as a community:

...Contrary to many others I have maintained a close relationship with my family...And that of course matters a lot to me in my recovery. Because I hear...I speak to others with substance use problems, and they don't have any contact with their family. They (the family) have been there for me. Not pointing any finger...respecting me.

From this quote, we see that the participant maintained a family connection and thereby a source of mattering through his process of recovery, assisting his recovery process. As such, PSOC and mattering facilitated the recovery process. However, it also seemed as if recovery facilitated a stronger PSOC and mattering within the family: the family as a community had a shared experience of going through a demanding process of recovery, where respect was a key ingredient. Once again, we see the reciprocal relations between recovery and PSOC and their impact on conditions of mattering (see figure 2).

Recovery and PSOC were also described as central conditions for the possibility and eagerness of adding value to others:

When I started to feel better, I was about to go to The Church City Mission and ask if they needed a hand. When I get better again, I want to do that...most likely, that is what I will do when I have recovered. Make an effort, a volunteering effort in my community. As long as my body can take it.

A similar experience was shared by another participant who in his process of recovery from polysubstance use developed a positive PSOC in the Salvation Army, which again resulted in enhanced self-esteem and a desire to add value to others in his local community. Moreover, adding value could be small practical things like janitor services at the institution one resided in, hosting get-togethers for residents, but also more wide-ranging things like "giving back to society":

...there are a lot of us (with substance use problems) who experience great value in giving back to society...there are people like me who have the need to “OK, I know how you should do that, and I can assist you and help you”. That is important and shouldn't be ignored.

As such, an interrelation between recovery processes, PSOC and mattering - both the dimension of feeling valued by self and others, as well as adding value to self and others - were evident in the older adults’ experiences of recovery from different substance use problems.

Health and mobility as conditions for mattering
Health and mobility are crucial conditions for older adults’ community involvement, also for those with substance use problems (44). From the participants’ descriptions it seemed as if weakening health and isolation were constrains for mattering that just had to be accepted in old age:

It's, just that I can't get outside with my situation of health. My balance is bad and different things makes it hard to get around. When you become older, you become more alone kind of, and you don't want to burden your family or anyone else...with ageing you aren't able to being useful or contribute as much anymore...

Physical limitations were described as placing severe constraints on the participant's ability to contribute; feel like they matter, and experience community [3].

Some participants were clearly troubled by the consequences of the constrains of their declining health and physical mobility:

You know. I really miss that (participating in activities). I am not doing anything. I just sit here and watch TV and do nothing. And it's a bit depressing. I would like to be more out and about. Do something that matters. But when you sit in a wheelchair and get old, it's not so easy (begins to cry).

Thus, having others (e.g., community members or service professionals) who could help them in getting "out and about" were be crucial for mattering for the participants in their recovery processes.

**Relationships as conditions for mattering: relational and service-related communities**

There are findings suggesting that older adults experience mattering primarily to their children (33). This was reflected in the fact that the participants described family related mattering as a condition in early stages of the recovery process. Experiences of being valued by the family and adding value to them were often connected to getting help and support from services in their process of recovery:

P: And, then the fight (for help) started. Because there wasn't any offer that wanted to take me in. So, then I said that "I have to get an offer now". And my son said the same. "If not, she is going to die".

I: So, your son came to the rescue?

P: Yes, he supported me.

I: What meaning has it had for you that the family and your children have been involved in the recovery process?

P: That has meant everything to me. If I had been alone in that process, then...I'm not so sure I would be here today. Then I don't think I would have felt that I mattered or had anything to live for, frankly.

I: Can you elaborate on that?

P: Just that you gain your courage to live. Because that was completely gone (in the beginning of the process).

Mattering to one's grown-up children was a necessary condition for a service-assisted recovery process; and as a consequence, recovery process outcomes such as illness management and courage to live became conditions for strengthened mattering between the older adults and their grown-up children.

For those participants who did not have relational communities to support them in their process of recovery, experiences of mattering in service-related relationships were crucial to their recovery [5]:

P: X (psychologist) knew that I had tried to end my life, so she had something concrete to deal with. It was evident that I needed to get back on my feet. For a long time, everything was so insecure. I just felt that I and my general practitioner couldn't make my life matter to me. I ran. Exercised every day and did all that I could (to manage health), but things were just not right. But with X, she made me see the value in things.

I: What significance has that had for you?

P: Very much. Like I matter.

Taken together, these examples illustrate that mattering in relational communities and service relationships were experienced as crucial conditions to the participants' early stages of their recovery processes and their access to services. With an elaborated recovery process then, the experience of being valued by and adding value to self and others could flourish.

**A stable home as condition for mattering**

Having a home, a stable place to live, can be crucial to our experience of feeling valued (45). As a final condition for later life mattering, we will highlight a complementary case of one participant describing the significance of having a stable home for his mattering:

I had my own apartment. That was the first time I felt like a human being. I and my wife. To live in an apartment you know, just wow! And then we could get financial support, right? Because the people at the bank saw us in a different way then. You were treated like a human being right away. Like... "Tell me how you live and I will tell you what kind of human you are, right?" To have your own apartment means everything. And, to get away from the drugs, that you don't live in a staircase with 50 addicts.
This example is illustrative and complementary to the subject matter, suggesting that a stable home was another central condition for the participants’ experience of being valued by self and others.

2. Experiences of mattering from community relationships

Relational, family and partner experiences of mattering:

Family can promote both protective (e.g., support and positive PSOC) and inhibiting factors (e.g. trauma and exposure to substance use) through recovery processes (42, 46, 47). In the current analyses families also seemed to have a mixed role, both as a source of mattering and not mattering for the recovering person. The following is an example of how families could promote central elements of not mattering, such as disrespect and devaluation:

...Once I celebrated Christmas with a close relative and her children when they were still little children. I had brought gifts for them, and their mother had opened their gifts and decided that they should not have those gifts and thrown them in the bin. So, when I asked the children if they liked the gifts, they just looked at me as question marks. I have no words. It was so rude! After that, I didn't want to celebrate Christmas with my family.

Persons with substance use problems often have strained relationships to their family. Such strains may turn sources of mattering, such as the family, into sources of not mattering. The participants’ descriptions suggested that, just as there can be a fine line between love and hate in families, there can also be a fine line between mattering and not mattering.

Loss of family or partner-related mattering through death was another factor that could prevent mattering and meaning in old age; sometimes resulting in suicide ideation:

P: You know. Sometimes I wonder, what is the point of living? You know (cries)?
I: Can you talk to someone about that?

P: No, I haven't done that. My partner died many years ago...And I miss him so much...two or three months ago I thought about ending my life. In the mornings I wake up and put my hand over at his side of the bed...then I feel that he is gone...everything has been heavy and empty after he died...

Mattering among friends

Friends can be an important source for mattering in later life recovery and this was evident in the material. Like for family and partner, loss of friend-related mattering through death was an experience promoting lack of mattering in later life: “We knew each other about 20 years. When he died, I didn't feel that I mattered anymore”.

In addition, there were descriptions of respect and similarity as important ingredients of friend-related mattering. Once again, the participants’ descriptions suggested that later life mattering largely resided in relational communities. As indicated in the description of the former theme, there were, however, also examples of service-related experiences of mattering.

Service-related experiences of mattering:

The older adult participants were all in recovery and in contact with the services offered to those having substance use problems. These services were described as promoting experiences of mattering mainly by dialogue and practical help.

The importance of talking with someone

To experience mattering, we must be told or shown by others that we are of value to them. Several participants described how important it was to talk with service providers to experience mattering:

P: I talked with my doctor, and he was very nice. Very welcoming. I got a lot out of taking to him.
I: Can you say a little more about what you mean?
P: Yes, he was very good. I have to say.
I: But if you were to describe what you valued? What was it that he did?
P: I don't know.
I: Was it that he talked with you?
P: He talked with me and not to me.
I: And what would you say is the main difference? Of talking with and to?
P: To talk to, it to kind of say «now you will do that and that»...
I: Like a command?
P: Yes. But he didn't do that. He was welcoming and understood.

I: And, talking with. What is that?

P: That he could see my problems. That they mattered and that he would try to fix those problems.

Participants also shared experiences of not mattering in the meeting with service professionals (often home nurses) which did not have time to talk to them:

I think they could add a little to the conversation. “How are you?” “Are you doing good?” Ask a little bit about those things. I feel that is lacking in these home services. They don't have the time to talk to people...That gives me a negative experience.

The value of being prioritized and paid attention to

Another related part of the participants’ descriptions of mattering in contact with service providers was the value for them of experiencing being helped and prioritized:

I was admitted to hospital for alcoholism...and I was there for two or three days, and then I felt that I got a really good follow-up in the way that I was prioritized, or given attention, right? That “you have a need and we will help you”...that mattered a lot to me.

However, there were also nuances to this sub-theme suggesting that services could promote the opposite: an experience and feeling ignored, that no one cares or want to help you as a “drug addict”.

I: If you could get any help that you desired (for your recovery)? How would that service look like?

P: Well...I have to base my answer on my own experience. And...that is that you have to be so sick that you are dying (before you get help). It shouldn't be necessary to fight to get help. In that case the offer should be there. I am aunt of two persons who have taken their life. Both being drug addicts. And they were calling for help but weren't prioritized. So, I am not impressed (by the services offered).

[3] There were similar descriptions by participants having problematic use of illegal substances.
[4] P is an abbreviation for participant and I for interviewer
[5] For this theme there were similar experiences shared by participants having polysubstance use.
[6] These findings applied to the experiences of participants having alcohol problems and polysubstance use.
[7] This theme is based on descriptions from participants having alcohol problems and problems with illegal substance use (amphetamine/polysubstance use)

Discussion

We all need to feel valued by, and add value to, self and others throughout life. Older adults with substance use problems is a group on a steep rise in several Western societies (22–24). Thus, there is a pressing need today for substance use services tailored for this group (24–26). Moreover, in order for substance use services to promote mattering for the many older adults they encounter, there is a need to better understand mattering among older adults receiving substance use services in their recovery processes. The aim of this study was to explore and understand conditions and experiences of mattering for older adults in service-assisted recovery processes from substance use problems.

Taken together, the findings show different conditions for experiences of mattering and not mattering (see Table 2). Moreover, the findings reflect several previous findings of later life mattering: that both mattering and not mattering are central parts of older adults’ experiences (12, 14, 20); that belonging and mattering are distinct but interrelated concepts for older adults (20, 21); that mattering and a sense of being seen are important in later life recovery processes (48); and that loss of mattering (by death) and capacity (by declining health) of mattering are particular features of later life mattering (20). Importantly, reflecting these previous findings, the findings suggest that they may be relevant also to the experiences of older adults in service-assisted recovery processes from substance use problems.

The findings provide some additional new insights. The overarching theme in the material was about later life mattering as an interrelated and multidimensional process. Mattering as a concept seemed to evolve in a reciprocal interrelation with recovery and relational PSOC: having multiple sources (e.g. family, and services) and including experiences of both mattering and not mattering. Moreover, the findings provide insight to elements of adding value to others, which prior research on later life mattering rarely address. The participants’ desire to add value to others seemed to be promoted by PSOC and recovery, once again indicating an interrelation between PSOC, recovery and mattering. These new insights are in line with prior and more general proposals of mattering as a multidimensional concept, co-created in multiple communities (49). Moreover, they nuance the current understanding of later life capacity of mattering by suggesting that this aspect also includes social resources. Although health and illness management are important ingredients to later life capacity in recovery processes, later life capacity is not only about individual ability to matter, but also about the available social resources at hand to enable courage to live and the capacity to matter.

Finally, we cannot underline enough the important observation that there was an over-all experience of not mattering among the participants (see Fig. 1, stage 2). Several of the participants’ accounts were about experiences of not mattering; promoted by relational communities’ lack of support, disrespect and devaluation and loss of relationships due to death, but also being ignored and not receiving fair treatment and help by service professionals. As such, the findings suggest that some older adults with substance use problems may be particularly subjected to the negative effects of not mattering, such as suicidal ideation and attempts (Elliott et al., 2005; Moore, 1997; Olcoń et al., 2017; Pope et al., 2006), depression (Flett et al., 2020; Krygsman et al., 2022), loneliness...
(Akhter-Khan et al., 2022), overall stress (Taylor et al., 2019), marginalization and experiences of being excluded, devalued, and disrespected (Flett, 2022). Thus, extensive efforts should be initiated to promote the therapeutic and preventive potential of later life mattering for the growing population of older adults with substance use problems.

### Table 2
Overview of themes and sub-themes

<table>
<thead>
<tr>
<th>Theme 1: Conditions for mattering</th>
<th>Theme 2: Experiences of mattering</th>
<th>Experiences of not mattering</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interrelation with recovery and PSOC.</td>
<td>Relational communities:</td>
<td>Not receiving support, experiences of disrespect and devaluation, loss of relationships through death.</td>
</tr>
<tr>
<td>Health and mobility.</td>
<td>Support in recovery, similarity and respect.</td>
<td>Service-related communities:</td>
</tr>
<tr>
<td>Relationships in relational and service-related communities.</td>
<td>Having someone to talk with, being prioritized and given attention to.</td>
<td>Being ignored, not receiving fair treatment and help.</td>
</tr>
<tr>
<td>A stable home.</td>
<td></td>
<td></td>
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</tbody>
</table>

Consistent with the findings of the study, we suggest that older adults in service-assisted recovery processes should be supported in staying connected to family and friends able to facilitate mattering. Network meetings and the involvement of significant others in treatment are concrete examples for how substance use services can promote sources of mattering for older adults in recovery. In these meetings and involvement, it is important that service providers assist older adults in clearly communicating what they need from family and friends, and clearly ask family and friends what they can do. The findings suggest that mattering is enhanced through help, respect and reciprocal satisfaction of needs. We can say that mattering, PSOC and recovery are co-created. This is where friends and family come into play with the recovering individual and his/her services. Another central task for service professionals is to balance the fine line between experiences of mattering and not mattering in the involvement of relational communities.

Our findings also indicate that several service-related elements promote experiences of *not* mattering (e.g., not being prioritized or ignoring social needs), which can be destructive to older adults’ recovery (14, 48). When it comes to service-providers, it is essential to make both the recovering person and significant others feel welcomed, that they are being listened to, helped, and prioritized. It is important to avoid the experience of being talked to, and rather talk with the older adult and their relations. Furthermore, the findings indicate that some older adult service users may be in particular risk of losing community belonging and mattering in everyday life (e.g. due to loss of partner, loss of friends or decline in health and mobility). Increased investment in service users at the time of such psychosocial transitions can be a crucial step to prevent experiences of not mattering. Also, the participants’ descriptions suggests that older adults living and recovering in their home need additional service options that can fulfil their basic social needs. We advise that outreach services such as Flexible Assertive Community Treatment (FACT) Teams tailored for older adults should be strengthened and offered more widespread. Such services are crucial when health policy, for example in Norway, is structured around the ideal of keeping older adults in the home for as long as possible. They also become increasingly important to secure the social needs and health of the growing population of older adults with substance use problems.

Directories of health, municipal health services organizations and society at large also have roles to play. These organizations can institute preventive and promoting policies, programs and practices on mattering among recovering older individuals. Training of service providers (e.g. home nurses, low threshold services and FACT team professionals) in the promotion of mattering, and developing programs where recovering service users can feel valued, but also add value to others, are also central steps to improve public health. In addition, society needs to build communities and social networks more systematically around older adults in recovery. This may entail providing affordable housing and the nourishment of supportive communities, where each person can have a meaningful role. Finally, municipalities may develop Asset Based Community Development (ABCD) programs (Russell & McKnight, 2022) for promoting mattering between generations of citizens, including older adults in recovery from substance use problems. Our findings suggest that several older adults in service-assisted recovery have a desire to be part of and use their assets to add value to their community and society. It is up to policy and communities to make sure that these potential assets come to life through tailored programs and available sources of mattering.

Strengths, limitations and future research

There are several strengths and limitations to this study. First, this study includes a rather heterogeneous sample of older adults with different substance use problems. However, the size of the sample still restrict the transferability to the larger population. Furthermore, we were not able to include more than 7 women with alcohol and medicine problems. Most likely, this restricted our understanding of nuances in older adult women’s experiences of mattering and recovery from these two substance use problems. It also means that the experiences of older adult women recovering from illegal substance use problems were not included in the material.

Furthermore, this study is based on a deductive and theoretical analysis. This type of analysis may restrict the understanding of participants’ concepts of mattering to the existing theoretical framework.
To understand concepts of mattering among older adults in recovery more broadly, there is a need for additional qualitative explorative studies including samples reflecting the demographic profile of the population, and who apply an explorative and inductive approach to the analysis. Based on the findings of such investigations, one may consider developing new and valid measures of mattering to apply in larger quantitative studies, with increased possibility of transferring results to the larger population. Given that service systems and social-cultural contexts may differ greatly and affect concepts of mattering across the world, it is important that future studies are planned and undertaken in a context-sensitive way. Finally, one of the greatest strengths of this study is the collaborative the multi-perspective approach to the analysis. This is likely to have enhanced reflexivity and interpretive depth. Future collaborative analyses should consider the possibility of including the perspective of older adult peer researchers to advance a valid understanding of older adults' experiences.

Conclusions

We have investigated mattering among older adults in service-assisted recovery processes from different types substance use: alcohol, medication and illegal substances. Taken together, conditions for and experiences of mattering for the participants seem to depend on fair and healthy relationships; fair distribution of resources such as affordable housing, accessible transportation, and fair organizational structures where they can feel valued and have a chance themselves to add value. Importantly, reciprocal relations between mattering, recovery and PSOC seemed to influence conditions of mattering. These interrelations also seemed to be significant for the older adults’ access to substance use services. We have suggested several approaches to promote mattering for older adults in service-assisted recovery processes. At this point, however, more evidence about later life mattering is strongly needed to develop services tailored for promoting mattering and preventing lack of mattering for the growing population of older adults with substance use problems, their relationships and communities.

Declarations

Ethics approval and consent to participate

The larger national study, from which the material for this study was derived, was performed in line with the principles of the Declaration of Helsinki. Ethical approval was reviewed and deemed unnecessary by the Regional Committee for Medical and Health Research Ethics (national legislation of the Health Research Act). Ethical approval was also applied and granted by the Data Protection Officer at St. Olavs hospital in Trondheim, Norway (Reference ID: ESA 17/4211). Consistent with this approval, all human participants were informed about what their participation would involve, who would conduct the interview, and that the interview would be anonymised and transcribed word for word, before being analysed and published in reports and articles. The participants were also asked if the interview could be digitally audio-recorded, of which 2 participants declined. These two interviews were recorded by written notes by the second author. Finally, before conducting the interviews, each participant was informed that they could withdraw their consent and end the interview as they wished. All participants signed a written informed consent before the interviews took place.

Consent for publication

Not applicable

Availability of data and materials

All documents from the analysis are available upon request from the corresponding author. Due to ethical and privacy concerns for the participants, the full data set is not available.

Funding

The study utilized data from a larger national project evaluating service users’ experiences with substance use treatment services from Norwegian municipalities. This national project was funded by the Norwegian Directory of Health.

Competing interests

The authors declare that they have no financial or non-financial interests to disclose.

Footnotes

1) Participants are represented with codes indicating their gender (F for female, M for male) and age.

2) Interviewer 1 is the fourth author and an academic researcher; Interviewers 2 and 3 worked at The Drug and Alcohol Competence Centre in Central Norway, interviewers 4 and 5 worked at The Drug and Alcohol Competence Centre in Oslo. All interviewers had academic training in conducting interviews (5 of 5) and 3 of 5 had clinical competence in communication with individuals with substance use problems.

3) There were similar descriptions by participants having problematic use of illegal substances.
4) P is an abbreviation for participant and I for interviewer

5) For this theme there were similar experiences shared by participants having polysubstance use.

6) These findings applied to the experiences of participants having alcohol problems and polysubstance use.

7) This theme is based on descriptions from participants having alcohol problems and problems with illegal substance use (amphetamine/polysubstance use)

**Authors contributions**

Nina Kavita Heggen Bahl: Has had the main responsibility of planning the overall study, leading and conducting analyses, interpretation of data, writing and leading the collaboration behind the manuscript.

Hilde E. Nafstad: Has collaborated in writing the manuscript, giving advice on analyses and contributed with advice for improving the manuscript text.

Rolv Mikkel Blakar: Has collaborated in writing the manuscript, giving advice on analyses and contributed with advice for improving the manuscript text.

Emil Øversveen: Has collaborated in all stages of the analysis and given feedback on the manuscript throughout the writing process.

Morten Brodahl: Has collaborated in all stages of the analysis and given feedback on the manuscript throughout the writing process.

Ottar Ness: Has contributed to the overall manuscript text, with a particular focus on the methodological section. He has given advice on the presentation of themes and suggested literature for the article.

Isaac Prilleltensky: Has written a substantial part of the introduction, provided editorial advice on the overall manuscript, and had a leading role the final stage of the development of themes.

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**References**


Figures

Stage 1

Main themes: N.K.C. B

Mattering as a concept: for older adults with substance use problems, mattering is a process that is interrelated with PSOC and recovery. It does not necessarily fit (good). Value in taking care/responsibility for oneself/adding value to oneself. Valuing personal characteristics (for recovery). Adding value to others. Value of being normal. Respect as important for mattering. Being self-reliant matters. Mattering as relative. Current level of mattering is compared to earlier levels of mattering. Mattering in old age as expected to be less. Maintaining personal interests/memorable activities/physical exercise from earlier life stages important for mattering.

Service-related matters: Mattering as enshrined. The importance of talking with someone/projected or transformed. PSOC, Service promoted realization needed for the experience of mattering. The relationship of help/helping to others, Co-created mattering. The importance of similar/peer persons. A stable home/safety as important for mattering.


Stage 2

Main themes: M. B.

General experience of not mattering.

Health and mobility as premises for mattering.

Meaningful achievements as key ingredients for mattering.

Dependency as important for mattering: Having others depending on you.

Mattering and recovery: You need some level of stability to experience mattering. You have to be healthy enough to matter.

Figure 1

Development of themes

Figure 2

Recovery and psychological sense of community as interrelated conditions for mattering.