Elderly Well-Being and Alcohol: A Tricky Cocktail

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Abstract
This interdisciplinary study is concerned with the well-being of older adults and how this relates to alcohol. Older adults’ use of alcohol in nursing homes is a rising challenge in Western societies, expected to increase in the coming 10–15 years. Alcohol use has consequences that go beyond mere health concerns and stretch into social, personal, and institutionalized life. The present study aims to develop procedures and guidelines for handling alcohol in elderly care, assist in handling value conflicts, ease the work of care workers, and more generally ensure a better quality of life for older adults. The study has four phases: (1) exploration, (2) interpretation in collaboration with practitioners, (3) developing practice-oriented product, and 4) implementation. Phase 1 was conducted in 2018. In this phase, observations were carried out in five care institutions in a Danish Municipality for a total of 25 days. These observations led to the development of interview guides. Based on the interview guides, 31 participants (residents, care workers, relatives and managers) were interviewed for 30–60 min at the five institutions. In Phase 2, data will be analyzed and interpreted by the researchers in collaboration with representatives from the five institutions. Phases 3 and 4 are forthcoming, and the study is scheduled to terminate in 2021.

Keywords
well-being, older adults, alcohol, qualitative research, philosophy, interdisciplinary approach

Background
Older adults’ use of alcohol is a growing challenge for elderly care. Older adults are more sensitive to the negative health consequences of alcohol than younger age groups, which might contribute to cognitive impairment. Presumably, alcohol can be a contributing factor in dementia (Gupta & Warner, 2008; Hislop et al., 1995), even though this has yet to be proven unequivocally (Ilomaki et al., 2015). At the same time, there is a tendency to downplay the problem: Considering that older persons have a shorter life expectancy, do the problems really matter? Should we deprive them of their last remaining pleasures? Alcohol has symbolic functions and can be a condition for successful socializing. It is also used widely as self-medication, with or without conscious intent. It can be an important part of the older person’s self-image as cheerful, emancipated, and so on. Moreover, there is evidence that moderate consumption of alcohol can postpone dementia and may also have other (moderate) health effects (although not to a degree where abstinence is not more favorable; according to Ilomaki et al., 2015).

A strong focus on life quality makes it challenging to maintain a one-sidedly critical attitude toward older adults’ use of alcohol. The same holds for the concern for autonomy. Elderly care professionals are keen to avoid moralizing and intruding on the personal affairs of older adults. At the same time, there is a widespread expectation that older adults ought to “behave themselves.” Thus, different values, habits, prejudices and expectations come into conflict. The use and handling of alcohol is, in this way, paradigmatic: It exemplifies many of the general challenges and dilemmas related to attempts at ensuring a good life for older adults. It is not just a case of the tricky

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balance between beneficence and respect for autonomy implied in the central concept of care, which already expresses an asymmetrical relation between care professionals and older adults (Vetlesen, 2008, p. 132 f.). There is also a range of more subtle, widespread dilemmas. How should one, for example, balance the documented beneficial health effects of a particular intervention with its more subjective or symbolic effects—for example, experiences of coercion, lack of understanding, sympathetic insight, “health-tyranny,” and so on? The relatives of elderly persons, presumably, play an important role as well. They may assist the care professionals with otherwise difficult conversations about alcohol and related matters but can also add to the problem (due to the general drinking habits in the family or through their “complicity” in the older person’s alcohol abuse). Without centrally defined guidelines, it is up to the care workers themselves to supervise/guide and handle potential conflicts. In the municipality, attempts are currently made at developing and implementing so-called innovation goals. They focus on immaterial welfare, which is found to be declining. This decline increases the need for material welfare in the form of welfare benefits. Until 2020, the welfare administration will be focusing on loneliness, special efforts for mentally vulnerable people and people with physical disabilities, and older adults.

The municipality officials are aware of being in a time of rapid change and see the current tendencies as foreshadowing more substantial changes in the future. In the long run, it will be necessary to accommodate a more diverse population with respect to cultural background, values, and lifestyle. This will pose new challenges for elderly care. Generally, it is widely recognized that older adults are just as diverse as younger citizens (Jensen, 2002), but in eldercare, it has been difficult to convert this insight into a sensitive and differentiated practice.

Requests From the Field of Practice

The Vejle municipality described their wishes and needs as follows:

I. Tracking of alcohol problems before the citizen arrives at a care home
II. Preventive efforts for alcohol problems
III. Development of tools for handling alcohol problems/use of alcohol in care homes
IV. Clarification of what is already established practice and how these procedures work, with the intention of revising these conditions in relation to the findings of the present study
V. Clarification of the concepts of life quality and immaterial welfare in eldercare and help with the development and implementation of innovation goals.

The project Elderly well-being and alcohol—a tricky cocktail is meant to target III, IV, and V. The aim of the project is to produce new knowledge of the extent of the problem, its facets and manifestations, and to deliver important preconditions for the work in Project A and B. Even though V is developed with particular focus on alcohol problems, it goes far beyond this. By treating alcohol problems as exemplary, and by investigating the well-being of older adults more generally, we ensure that the results of the present project have wide-ranging possibilities of being transferred to other areas.

Problem Formulation, Delimitation, and Project Structure

The overall research and development question of the project is:

- How can the handling of alcohol use in eldercare be improved to increase the quality of life for older adults and ease the work of care professionals?

We address this question by investigating the following research questions:

a. How should older adults’ well-being (and the good life in old age) be understood? How can this understanding be formulated and operationalized to improve practices and guidelines for elderly care?

b. How can a process-oriented well-being theory be developed and utilized to describe and improve the handling of values and value conflicts in practice?

c. Which value conflicts (and processes that likewise involve values) in relation to alcohol are prevalent in different areas of eldercare? How are these value processes handled, and how can we ensure that their handling is improved?

d. How can the official “innovation goals” of the municipality be elaborated and specified, with particular focus on the development of a philosophically well-founded, conceptually clarified, and sufficiently operationalizable measure of well-being?

Participating Institutions

The empirical focus of the project is the care home residents and care workers in the municipality. To a lesser extent, the focus is also on those older adults who receive home care, cleaning staff, and relatives. The central focus is the verbal and nonverbal interaction between older adults, care staff, and relatives. Of special interest to the investigation is the so-called temporary accommodation. These are used for situations that require urgent care and are also used for the clarification and assessment of dementia, as well as rehabilitation. The massive flow of older adults in different life phases, and with many different problems in these accommodations, makes this area an obvious target for investigation.

The two care homes, the Temporary Accommodations and the home care unit, were chosen, partly, because the management and staff have expressed their wish to participate, and partly because they—as a whole—cover a representative segment of the older adults in need of care (there is a dispersion in socioeconomic background). Furthermore, we have included
the Practical Assistance unit. The management estimates that the cleaning staff is more familiar with the older adults than the care workers. The staff expressly asked for tools to increase the awareness and understanding of older adults’ life quality and has confirmed that alcohol is a steadily growing problem.

The widespread occurrence of dementia among older adults poses a particular challenge for the present project. Around 85% of all care home residents show signs of dementia in some form according to the Vejle municipality. The project is not centrally concerned with dementia. However, the problem of dementia is not just a practical challenge but also a motivating factor. Even if the exact link between alcohol and dementia is still unknown, the connection is supposed to exist, is a given in the nursing homes. The prevalence of dementia can make conversations that are already difficult, even more challenging. It can create problems with understanding, not just for the staff but also for researchers.

State of the Art and Theoretical Foundation

The theoretical and empirical focus of the project has been shaped by extensive preliminary conversations with representatives from the municipality, who reported their views on what are the main challenges to ensuring a good life for older adults. The project is thus an example of stakeholder-driven research, as the research questions have been chosen and formulated in response to a documented need among care professionals, rather than to specific hypotheses or questions drawn from the research literature. A review of the extant literature shows that these questions have been only marginally addressed in prior research, confirming their importance. Recent Finnish and Swedish studies of care staff dealing with older adults’ alcohol use (Karlsson & Gunnarson, 2017; Koivula et al., 2016) strongly emphasize the need for more in-depth research in the field. These studies closely confirm the reports we obtained from the municipality, which pointed to a lack of guidelines for the handling of alcohol, as well as a need for more training and knowledge among care professionals, who are often confronted with the dilemmas described above and experience themselves to be acting from emotions like disgust or pity.

Older Adults and Alcohol. Existing research is either incomplete or less relevant to the specific questions of this study. Until now, research in addictions has mainly focused on younger age groups, and specifically studies that target the wider social, cultural and existential context and implications of alcohol use remain very rare. There has been little research on older adults in care homes and home care and their use of alcohol (the authors, forthcoming). Estimates of the prevalence of alcohol use and dependence in care homes vary widely depending on care home specialization (Seitz et al., 2010). Further, the effects of the use of alcohol among older adults in care homes has seen limited research (see Brennan, 2005; Kaplan et al., 2014). A few studies have investigated causes and motivations for using alcohol in care homes, pointing to socialization as one possible motivation (see Burruss et al., 2014; Sacco et al., 2015). Barry and Blow (2016) showed that the baby boomer generation tends to continue a high use of alcohol into old age, confirming reports and expectations from the municipality officials. An ongoing study of the treatment of alcohol use disorder among older adults in Denmark, Germany, and New Mexico (USA) is trying to amend this by testing two variations of brief interventions specifically aimed at older adults (Andersen et al., 2015; for earlier studies, see Lemke & Moos, 2003; Nielsen et al., 2010). Liberto and Oslin (1995), Emiliussen, Nielsen, and Andersen (2017), and Emiliussen, Andersen, and Nielsen (2017) have uncovered the clinical differences between early and very late onset alcohol use disorder among older adults. Merrick et al. (2008), Weyerer et al. (2009), and Blazer and Wu (2011) have studied the correlation between older adults’ use of alcohol, sociodemographic variables and general health conditions. Blow et al. (2007) have investigated the complex relationship between depression and alcohol use in older adults. None of these studies, however, target the broader connections between handling and use of alcohol, general concerns for well-being and factors related to culture and identity. An exception is Alasuturis’s (1992) groundbreaking ethnographic and culture-theoretical study of alcohol problems which, among other things, points to the connections between alcohol use disorder, the formation of identity and the understanding of freedom, and emphasizes the importance of the specific cultural context; it does not, however, deal with the special case of older adults in care facilities or receiving home care.

Philosophy. For the past 20 years, well-being has been the object of extensive empirical investigations (Diener, 2009; Eid & Larsen, 2008; Kahnemann et al., 1999). It is usually presumed that well-being consists of a combination of, mainly, positive affect and life satisfaction—a presumption based as much on considerations about measurability as on careful considerations concerning the nature of the phenomena. In philosophy, the discussion is ongoing between proponents of hedonism (e.g., Bramble, 2016; Crisp, 2006), desire-fulfillment theories (e.g., Parfit, 1984; Rawls, 1971) and objective list theories (Griffin, 1986; Hurka, 1993, 2011). It is the goal of the present study to add to this discussion by developing theory based on empirical data.

We understand well-being as a normative concept about that which is fundamentally good for a human being (Crisp, 2017). Well-being is what we care about when we care for another human being (Darwall, 2002), which is something care workers must do every day. We presume that well-being consists of a preponderance of positive experiences and positive emotions, and moods (Haybron, 2008), but factors like the authenticity of the experience (Sumner, 1996) and the agreement between desires and preferences are also elements of well-being. Tiberius (2008, 2015) suggests that well-being consists of value fulfillment over time. According to this view, the well-being of a person depends on the degree to which she experiences or achieves something that matches her values. It is especially relevant to elderly care because older adults’ possibilities for value fulfillment among older adults are usually reduced, or
different from what they used to be. This points to both special challenges and opportunities for care. One option that is pursued in the project is “cocreating” new and more realistic values, through interaction between care professionals and elderly citizens.

Well-being is usually understood as an aggregate of independent, time-neutral elements; contrary to this we will employ a holistic view (Klausen, 2017). A good life potentially contains further normative factors (Hayborn, 2008). This concept is also relevant both for assessing the quality of the lives of older adults and for analyzing the norms that guide the attitudes and actions of care professionals. There can easily be a mismatch between these norms of “good living” and the kind of living that the elderly citizen herself perceives as satisfactory. An important concept like dignity can be understood either as an element of human well-being, that transcends the mere subjective well-being, or as an element of the good life (dignity in eldercare is analyzed in Nordenfelt, 2009, but the concept needs further development). The need to study different and potentially conflicting understandings of well-being is one of the reasons for drawing on philosophical well-being theory as opposed to adopting the simpler approaches that dominate the health focused literature.

Older adults’ well-being and the good life for older adults have largely gone theoretically unnoticed. A new exception is Jeske (2016). De Beauvoir’s (1970/1993) comprehensive study of aging is still relatively unique and touches on alcohol use disorder in care homes (vol. 1, p. 298) but is mostly a critical study influenced by its time. Mollenkopf and Waterman (2007) include empirical studies that point to the fact that research has not taken laypeople’s (including that of older adults) understanding of life quality into consideration and has ignored everyday experiences (Bowling, 2007).

Emotion-based ethics and theories on emotions as something cognitive or rational have gained strong support over the last two decades (e.g., Baier, 1987, 2000; Thagaard, 2006; Haidt, 2001; Nussbaum, 2001; Roeser, 2011; Slote, 2010). In accordance with our phenomenological approach (Engelsen, 2017a; Scheler, 1913; Tappolet, 2000), we will presume that emotions are not necessarily propositional states or, at least, have more than propositional content (Goldie, 2000). Neither the question of the fundamental nature of emotions nor the meta-ethical questions are, however, crucial to the use of the theories for answering the research questions posed in the present project. This strategy allows for a relatively eclectic application of those theories.

**Aims**

The aims of this study are partly motivated by the lack of knowledge in literature, but still more by problems and themes for investigation, pointed out by stakeholders, especially care facility managers, in the preparatory phase (because of this, but also because of the use of participatory workshops throughout the project [see below], the study can be seen as an example of stakeholder-driven research). The study aims to expand on the knowledge of alcohol use in care homes and home care. Further, it seeks to expand on the interactions between older adults, care workers, relatives, and managers, to give an expansive foundation for in-depth knowledge in the area. It seeks to use this expanded knowledge to aid practice in care work and help reduce value conflicts and increase well-being for older adults.

**Design**

The present study was designed as a qualitative investigation based on observations and interviews. We chose a qualitative design as we wanted to attain knowledge of the participants’ opinions, life situations, attitudes, and experiences (Tanggaard & Brinkmann, 2010). Qualitative investigations are a well-suited format for attaining in-depth knowledge into a field of research and draws out nuances and insights that can be hard to reach with other methodologies.

We chose the observations for the present study since we wanted our investigation to be as ground-up as possible. Embedding ourselves in the field of investigation by utilizing observations allowed us to approach the views of the people involved as closely as we could. We wanted to obtain information on the groups and people in care homes and home care, to better understand how they live their everyday lives (Emerson et al., 2011). We also wanted a way to enter a setting with which we are unfamiliar. Hence, observations are uniquely useful for attaining the kind of insight we sought.

The purpose of the semi-structured interviews is to allow the participant to share their unique perspective with as little researcher guidance as possible. Augmenting the observations with semi-structured interviews is a way to direct our research toward themes and issues that became apparent during the observations. The interviews were used, both as a clarification of certain issues from the observations, but also as a more in-depth format, than what may be attainable in an everyday setting (i.e. during observations).

The present project was formally initialized on February 1, 2018. Prior to this, a series of preliminary meetings with representatives from the municipality, the care units, and the researchers were held to clarify and plan the execution of the study. The project consists of four phases: 1—clarification and exploration, 2—joint interpretation, 3—developing a tool, 4—implementation. Before the initiation of the four phases, there was a short phase for preparation and upstart in February and March 2018. This preliminary phase focused on the concrete plan for the execution of the study and the logistics concerning the data collection and the planning of how the researchers, municipality, home care, and care home units would be involved.

The full runtime of the project is from February 2018 to January 2021. It is vital for the success of the project that there is a close and continuous collaboration between the different subprojects and the project participants. To avoid the development of theory and the empirical investigations being conducted as isolated subprojects, the results from each will be shared consciously. We will ensure the link between the
theoretical and empirical studies through extensive use of coau-
thorship. The collaboration with the practitioners will be
ensured via the contact during the data collection and the work-
shops, as well as through newsletters.

Data Collection

Phase 1: Clarification and exploration (April 2018–October
2018). The first phase was an explorative phase, where we
conducted observations and interviews with the care workers,
residents, and relatives in the care units.

Observations

We made observations of the daily practice in all the care units
with particular focus on interaction concerning alcohol. These
observations were conducted with 12 care workers (two to
three in each care unit) on 2–3 work days for each. Hence,
we conducted 12–36 half days of observation. We also made
observations with two staff members in home care (2–3 half
days) and two staff members working in the practical assistance
unit (one full shift). The discrepancies between the number of
observation days in the care homes, home care, and practical
assistance unit was due to practical limitations. Every occasion
of observation required preparation and administration in the
care homes. Care workers had to accommodate observers to
some extent. Moreover, the home care units and the practical
assistant unit work at home with the residents. Hence, this work
involves much transport between residences. The observations
described above were conducted from March to June 2018.
During these observations, the authors and four student assis-
tants followed the care workers in their daily work to observe
practice. To the extent possible, they attempted to observe and
pose clarifying questions, when needed, regarding actions and
conversations during the workday. They made field notes dur-
ing their observations and wrote a field note journal at the end
of each day. These observations were entered into an excel
database.

Interviews

Later in Phase 1, but overlapping with Phase 2, we conducted a
series of semi-structured interviews. Interview participants
were chosen by the managers of the individual care units, who
also assisted in planning the interviews.

The individual interviews were semi-structured with 10 pre-
determined open questions (see Supplemental Appendices 1–4)
to ensure focus in the interviews, but giving enough space for
the participants to unfold their experiences. We developed four
different interview guides, one for each group of participants:
residents, care workers, relatives, and managers. The interview
guide was based on the observations, themes, and questions
that arose during the observations, with focus on alcohol cul-
ture and alcohol problems.

Participants and Recruitment

Participants for the interviews were recruited by management
selection (convenience sample). Every manager (five) from
each of the five municipal care facilities was asked to select
two participants from each group (residents, care workers, rela-
tives). Further, we asked all (five) managers to participate in an
interview as well. Hence, in an ideal design, we would inter-
view 35 participants in all. However, it turned out to be partic-
ularly challenging to recruit relatives in general. In some cases,
the interviewees were asked whether they wanted to interview
more participants than initially set once they were at the insti-
tution. Hence, a volunteer in the home care unit was also
included for interviewing (see Table 1).

We interviewed 31 participants: 12 residents (11 interviews,
two in one interview), 9 care workers, 6 persons from manage-
ment, 3 relatives of residents, and 1 volunteer worker. We
interviewed each participant for a period of 30–60 min. All the
interviews were transcribed semantically with focus on con-
tent.

A preliminary and tentative thematic categorization of the
transcripts served as a basis for parts of Phase 2.

Phase 2: Joint interpretation (November 2018–ongoing). In
this phase, the result of preliminary analyses was brought back
to the care workers and managers in workshops. Workshop
participants were the contact persons (often the manager) from
the care units and other interested personnel invited by the
contact person. All the researchers participated, as did at least
two practice participants from every care unit. These practice
participants were care workers and managers. In these work-
shops, samples from the data were chosen by the researchers to
be discussed by the workshop participants. The examples were
discussed to give the best possible basis for the development of
the final product (the tool mentioned in Phase 3—see below).

Phase 3: Developing a tool (ongoing). In this phase, the joint
interpretation (e) was transformed into an applicable tool for
the care units. This joint interpretation was based on the qua-
litative data accumulated in Phase 1 and took place over several
meetings. The qualitative findings formed a basis for discus-
sion among the researchers and contact persons from practice.
Researchers presented a selected number of examples from the
observations and the interviews and gave them to the contact
persons in an anonymized form. The contact persons then dis-
cussed the examples, and these proceedings were recorded by a

due to practical limitations. Every occasion
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of each day. These observations were entered into an excel
database.

Table 1. Participants.

<table>
<thead>
<tr>
<th>Group</th>
<th>Care Homes</th>
<th>Temporary Placement</th>
<th>Practical Assistance</th>
<th>Home Care</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
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<td>3</td>
<td>2</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Care workers</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Relatives</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Managers</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Volunteers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>31</td>
</tr>
</tbody>
</table>

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Researchers presented a selected number of examples from the
observations and the interviews and gave them to the contact
persons in an anonymized form. The contact persons then dis-
cussed the examples, and these proceedings were recorded by a
student worker. This formed the basis of the ongoing development of tools.

During the initial meetings with the contact persons of the individual care units, a wish for creating recommendations and guidelines that would equip the care workers with tools for talking about alcohol with the older adults was defined. Further, it was requested that findings be adapted for sharing in the care units (e.g., contents for flyers about the care homes), with the purpose of deflating the unqualified negative ideas that future residents and others might have about care homes. The product is meant to develop from Phases 1 and 2, and it is not easy to predict its precise nature in advance. Among the care workers, there is an understandable reservation about “guidelines” in the traditional sense, which is perceived to be linked to being placed under surveillance, a lack of trust in the care workers, and their individual capabilities for professional judgment. The development of the product will take place in close collaboration between practice participants and the researchers. This means that the contact person will partake in an ongoing dialogue with the researchers through a series of workshops, which might lead to one joint product, but may also lead to individual products based on the individual needs of the care units.

Phase 4: implementation (planned November 2019–June 2020). In this phase, the tool will be made available for the daily use of care units. As a conclusion to Phase 4, there will be a period of evaluation stretching from March 2020 to June 2020. During this period, there will be a series of workshops for all parties involved to develop material or a product to be tested in a broader context and extended to other care units in the municipality and, eventually, to other Danish municipalities.

Data Analysis and Interpretation
Data collected in the present study will form the empirical basis for several sub-studies. Hence, the analysis of data will progress in several different ways. However, as a basis for all the sub-studies, an initial ad hoc thematic categorization will be performed for both interviews and observations. This will aid further analysis and interpretation.

The theoretical foundation for data analysis is phenomenology in its broadest sense. These analyses will rest on phenomenological theorists (Gadamer, 1975, Heidegger, 2008, Husserl, 1976), but be further informed by analytical wellbeing and value theory (e.g., Haybron, 2008, Klausen, 2016; Tiberius, 2008).

Further analysis will take its departure in “Interpretative Phenomenological Analysis” (J. Smith et al., 2009), which is based on phenomenology (Heidegger, 2008; Zahavi, 2011), hermeneutics (Gadamer, 2007), and ideography.

As a basis of departure, the analysis will use Jackendoff’s theory of language and make use of the logic of conversations (Asher & Lascarides, 2003) and contextual semantics and pragmatics (Recanati, 2004). Jackendoff’s (2006, 2007) theory of value systems will be utilized to examine how the parties conceptualize and express values in communication and the effect this has on the interaction. It will be utilized to focus, specifically, on the principles of assigning values to entities such as alcohol, alcohol consumption, loneliness, festivities, guidelines, care workers, relatives, and so on. Principles provide grounds for assigning values to actions, objects, and persons and are based on nonformal inference rules, which involve values in antecedents and consequence. This will highlight how values may cause problems as well as solutions in various contexts and how meanings and thoughts, related to alcohol, shape social interaction.

Our main focus will be on the interplay between the wellbeing of elderly citizens and their identity formation, self-image and social interactions, as well as on emotions and moods, which are often more important to the well-being of a person than momentary experiences of pleasure or displeasure (Haybron, 2008).

Researchers, Institutional Affiliation, and International Corporation
The present project is carried out by a multidisciplinary team of researchers from the University of Southern Denmark, at The Department for the Study of Culture, and the Unit for Clinical Alcohol Research at the Department of Clinical Research. Further, it includes senior management at the municipality and center managers from the respective institutions involved.

The project has an international advisory board with the participation of Valerie Tiberius, University of Minnesota, Sabine Roersen, TU Delft and Sven Andreasson, Karolinska Institute in Stockholm. The project will also be affiliated with the Centre for Values-Based Practice at St. Catherine’s College, Oxford.

Dissemination
In order to support the need for knowledge-sharing in the Vejle care sector, the articles which are written in English will be disseminated in shorter, less theoretical articles in Danish specialist journals. The methodological considerations and experiences, especially concerning the integration of qualitative research and applied philosophy, will be presented in an anthology or monograph. The results and findings will be presented at the annual Vingsted seminar for alcohol treatment, The National Associations of Municipalities addiction conference (targeted to planners and decision makers in the municipalities), and the basic educations for alcohol treatment professionals, courses for front personnel in the municipalities, and other relevant conferences and courses for practitioners.

Ethics
The project protocol was processed by the Region of Southern Denmark Research Ethical Committee on February 22, 2018. All interviews and observation data have been anonymized with aliases and the exclusion of personal data. Data are stored
in accordance with the University of Southern Denmark Research and Innovation Organization (SDU RIO) Legal Services statements on data security. All interview participants have given their informed consent, and the unit managers have given informed consent to the observations being carried out. In cases of uncertainties regarding genuine consent from a resident, we will rely on staff and relatives, and in cases of doubt, we will not include the person in question. Since the study is not based on an intervention, there are no unique ethical problems with this. All parts of the study are carried out with an awareness that the emotional reactions of staff, residents, and relatives demand ethical sensibility and awareness of the situation.

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Supplemental Material
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