Late-onset Alcohol Use Disorder/Problem Drinking — Psychosocial Characteristics and the Role of Meaning and Purpose in Life

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I confirm that the work submitted is my own, except where work which has formed part of jointly authored publications has been included. My contribution and the other authors to this work has been explicitly indicated below[1]. I confirm that appropriate credit has been given within the thesis where reference has been made to the work of others.

[1]An amended and published version of chapter two was jointly authored:

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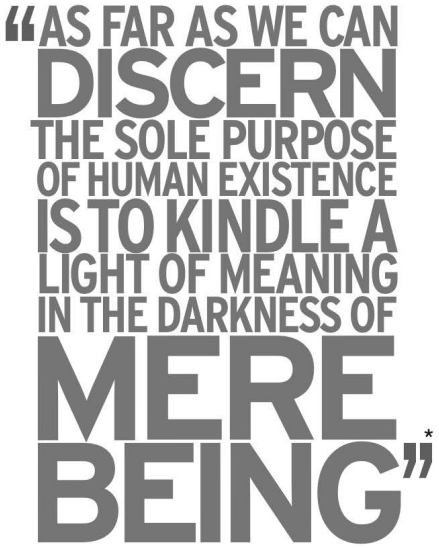

Dedicated to my darling Mother and my darling Christine.

Thank you for being lights of meaning when I was in the darkness,

and thank you for giving my life purpose.

*The above quote has been adapted from Jung (1983, p. 358). In its original form it reads: *"As far as we can discern the sole purpose of human existence is to kindle a light in the darkness of mere being"*. For the purpose of context, the words '*of meaning*' have been added.

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Abstract

This thesis is framed within Viktor Frankl's theory of meaning, logotherapy, which literally translates as "therapy through meaning" (Frankl, 2011, p. 19). The thesis reports the findings of three studies (two qualitative, one quantitative) that investigated the psychosocial characteristics, and the role of meaning and purpose in life, among early- and late-onset problem drinkers now in recovery, and also when they were drinking problematically. The thesis defined early-onset problem drinking as drinking that became problematic before 45-years old, predominantly before 30-years old, and late-onset problem drinking as drinking that becomes problematic later in life, mostly emerging between 45- and 55-years old.

The first study investigated the participants' retrospective, 'active drinking voices'. During this phase of the participants' narratives, a lack of meaning and purpose in life was prevalent in both groups; although there were some similarities, overall, there was more divergence than convergence between the groups regarding their psychosocial characteristics. The second study, which investigated the participants' 'recovery voices', found that there were more points of convergence than divergence between the psychosocial characteristics of the two groups. Finding meaning and purpose in life was equally important and prevalent in both groups. The final study used two scales, the 'Purpose in Life test' and the 'Meaning in Life Questionnaire', to measure each construct in recovery and found a significant relationship between meaning and purpose in life and time in recovery in both groups. The thesis suggests that Frankl's existential vacuum concept, a feeling that life has no meaning or purpose, is prevalent in problem drinkers, regardless of the age of onset. Conversely, again, regardless of the age of onset, the thesis further suggests that as time in recovery increases so too does the level of meaning and purpose in life.

Table of Contents Page

List of tables

List of figures Page

List of abbreviations

A.A. ..... Alcoholics Anonymous

AUD ..... Alcohol Use Disorder

CDAS ..... Community drug and alcohol services

IPA ..... Interpretative phenomenological analysis

MLQ ..... Meaning in Life Questionnaire

ONS ..... Office of National Statistics

PHE ..... Public Health England

RC ..... Recovery capital

RCPSYCH ..... Royal College of Psychiatrists

SAMHSA ..... Substance Abuse and Mental Health Services Administration

UK CDAS ..... UK Community Drug and Alcohol Services

UNODC ..... United Nations Office on Drugs and Crime

WHO ..... World Health Organization

GLOSSARY: Definitions of key concepts of alcohol consumption used throughout this thesis.

Alcohol dependence: Is a diagnostic term. The International Statistical Classification of Diseases and Related Health Problems – 10th revision (ICD-10, 2019) categorise *alcohol dependence* as a 'Dependence syndrome'. The ICD-10 define the syndrome as: "A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance (alcohol) use and that typically include a strong desire to take the drug (alcohol), difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug (alcohol) use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state."

Alcohol use disorder (AUD): Is a diagnostic term. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; APA, 2013) defines AUD as "a problematic pattern of alcohol use leading to clinically significant impairment or distress." AUD can be either mild, moderate, or severe. Criteria for receiving a diagnosis of AUD is dependent on the individual/patient having experienced any two of eleven symptoms (listed in the DSM 5th edition) in the previous 12 months.

Harmful alcohol consumption: The National Institute for Health and Care Excellence (NICE, 2010) define *Heavy drinking* as "high-risk drinking". That is, "alcohol consumption that is causing mental or physical damage. Consumption (units a week): Drinking ≥35 units (per week) for women or ≥50 units (per week) for men.

Hazardous alcohol consumption: The National Institute for Health and Care Excellence (NICE, 2010) define *Hazardous drinking* as "increasing risk drinking". That is, "A pattern of alcohol consumption that increases someone's risk of harm. As well as adverse physical and mental health consequences, this definition may also include adverse social consequences. Consumption (units a week): Drinking more than 14 but less than 35 units (per week) for women or more than 14 but less than 50 units (per week) for men.

Heavy drinking: *Heavy* drinking is a generic term used to describe alcohol consumption that is significantly above the defined Government guidelines for *moderate* drinking, which is defined as the consumption of 14 or fewer units of alcohol per week for both genders (Department of Health [DOH], 2016).

Problem drinking: *Problem* drinking is the preferred term used throughout this thesis; the rationale being, that *problem drinking* is less stigmatizing towards the individual compared to more diagnostic terminology (e.g., AUD, alcoholism). Additionally, *problem* drinking encompasses/captures a broader population of individuals whose drinking is above the recommended guidelines. *Problematic* alcohol consumption can be mild, moderate or severe, it is not dependent on the amount of alcohol consumed by the individual, rather it is the adverse physical, mental, emotional, psychological and societal experienced by the individual as a consequences of alcohol consumption.

Thesis Overview

Chapter One: *Thesis Introduction* — Briefly describes the overarching aims of the thesis, before presenting a thorough background and history of the subject matter, and the need for further research and knowledge in the area. The chapter introduces the thesis' theoretical framework.

Chapter Two: *Literature Review* — Investigates 26 relevant papers in the area of late-onset problem drinking, broadly concentrating on four areas: 1) Age of onset, 2) Gender differences, 3) Psychosocial and mental health characteristics, and 4) Meaning and purpose in life.

Chapter Three: *Methodology and Theoretical Framework* — Presents, in detail, the research aims of the thesis, briefly outlined in the introduction. The methodological framework and the research methods are discussed thoroughly, along with the thesis' theoretical framework: Frankl's theory of meaning, logotherapy, along with its epistemological and ontological positions. Also presented in the chapter is an overview of IPA.

Chapter Four: *The Active Drinking Voice* — Chapter four presents the first of two qualitative studies that use IPA to explore the two distinct voices that are present in the discourses of nine early- and nine late-onset problem drinkers: their retrospective, *active drinking voice* and their *voices of recovery*. Chapter four explores the psychosocial characteristics and the role of meaning and purpose in life that emerged from the first of these voices, the *active drinking voice*.

Chapter Five: *Voices of Recovery* — Chapter five, the second qualitative chapter, is a contrast to chapter four. Similarly, to chapter four, chapter five explores the psychosocial characteristics and the role of meaning and purpose in life, but from the perspective of recovery.

Chapter Six: *Having a Purpose in Life and Finding Meaning* — This chapter reports on the quantitative data analysis of 381 recovering problematic drinkers (n = 249 early-onset; n = 132 late-onset). It is a mixture of descriptive statistics and inferential statistics, based on the data collected from a demographic questionnaire (*descriptive*), and two psychometric measures (*inferential*), the Purpose in Life test and the MLQ.

Chapter Seven: *Discussion — Findings, Implications & Reflections* — This final chapter discusses the thesis holistically, beginning with a summary of the findings of the literature review and the thesis' three studies, followed by the practical implications of the thesis' contents. Theoretical implications are presented, along with implications for recovery. Contributions to the evidence base and implications to practice and policy are acknowledged. The thesis' limitations are then considered, along with recommendations for future research in the area, after which the author's reflections and account of the PhD journey are presented in the first person, before closing with the thesis' final conclusion

CHAPTER ONE

THESIS INTRODUCTION

"The late-onset[1] *alcoholics developed their alcoholism in later life, usually as a response to the stresses of aging."* (Zimberg, 1978, p.p. 27-28)

1.1 Aims

The overarching aims of the thesis are to investigate the psychosocial characteristics and the role of meaning and purpose in life, in a distinct demographic of problematic drinkers, who are said to constitute one-third of all older, problem drinkers (e.g., Christie et al., 2013; Schonfeld et al., 1987). This group are referred to as late-onset problem drinkers; the age range of this cohort will be determined during the course of the thesis. This is a considerably under-researched subject in the area of alcohol harm and alcohol dependency. It is hoped that the thesis' findings will inform the health and social care professionals who are most likely to come into contact with this unique population, whom the Royal College of Psychiatrists' (RCPSYCH, 2018) have described as *invisible*.

1.2 Background

Advances in healthcare and the efficacy of modern medicines means that people now have a greater life expectancy, with the majority living into their 60s (World Health Organization [WHO], 2015). In the UK, the growth rate of people aged 65 and over is faster than those under 65; in 2019 there were 12.4 million people aged over 65, an increase of 22.9% since 2009 (Office for National Statistics [ONS], 2020). A rapidly ageing population presents major challenges for the NHS and social care (Age UK, 2019), challenges compounded by an increase in alcohol misuse among older adults, who are consuming more alcohol than previous generations (Maclean et al., 2022). The physiological changes that occur in later life, such as greater sensitivity and reduced tolerance to alcohol, means that older people are at greater risk

of the adverse effects associated with dangerous levels of alcohol consumption (Giordano & Beckham et al., 2008; Ross, 2005; Wadd & Galvani, 2014).

The 'Baby Boomer' cohort of older drinkers, people born between 1946 and 1964, now aged between 60 and 78, account for almost half (47%) of all alcohol-related hospital admissions in England (Alcohol Policy UK, 2020), highlighting concerns about the unhealthy and problematic drinking behaviours of an ever-growing population of older adults. Between 2006 and 2018, there was almost a fourfold increase in the number of over 65s in treatment for problematic alcohol consumption, compared to a 37% increase among those aged 25–29, across the same timespan (Public Health England [PHE], cited in Drink Wise, Age Well, 2019). Additionally, the Health Survey for England 2019 (NHS, 2020), showed the highest proportion of respondents reporting drinking five days a week or more, were adults aged 55–74 (18%) followed by those aged 75 and over (17%), compared to 2% of those aged 16–24. The latest statistics for alcohol-specific deaths reflect this trend. In the UK the biggest increase in alcohol-specific deaths, is in the 55–64 age group; between 2001 and 2019, there was a statistically significant increase in the alcohol-specific death rate for people aged 55–79 years old (ONS, 2021a).

These alarming figures have been surpassed, due to the impact the COVID-19 pandemic has had on alcohol consumption in the population of older adults, with the largest increase of people in England drinking over 50 units a week in 2020, being among over-65s (Institute of Alcohol Studies [IAS], 2021). Moreover, 32% of adults aged 50–70 years old reported drinking more because of anxiety, and a loss of routine and structure, following the pandemic (Centre for Ageing Better, 2020). Additionally, COVID-19 has meant that many alcohol treatments, interventions and services in the UK were delivered remotely. However, uptake among older adults has been low, as many have difficulty engaging with online technology (Seddon et al., 2021). These findings, and those from other studies on alcohol use

among older adults during the pandemic (i.e., Rao et al., 2021), highlight both an increase in alcohol consumption among older people and the difficulty they experience accessing alcohol services.

Such bleak statistics are a compelling affirmation of the RCPSYCH's (2018) report on substance abuse (including alcohol), *Our Invisible Addicts*, which called for a national strategy on substance abuse and older adults. The report identified services ill-equipped to cope with the increase in alcohol-related health problems among the 'Baby Boomer' population. The staff at many services, including social care settings, the criminal justice system, older people's mental health settings and acute hospital settings do not have the specialist knowledge to deal with the biopsychosocial complexities that older alcohol misusers present with. Consequentially, the RCPSYCH (2018), and others (e.g., Crome & Crome, 2018) advocate bespoke services, in which staff have the "appropriate knowledge, skills and attitudes" to be able to identify, assess and treat this group (RCPSYCH, 2018, p. 4). Additionally, more research is needed in primary care prevention (Kelly et al., 2018b), where older adults who misuse alcohol are often not identified, and where factors such as ageism and stereotyping can result in signs of alcohol misuse (e.g., changes in mood) being mistaken for other symptoms, such as age-related depression (Rao et al., 2016). That said, a considerable body of literature has investigated risk factors associated with alcohol use disorder (AUD) and problem drinking in older adults (e.g., Gell et al., 2015; Moos et al., 2009; Wadd & Papadopoulos, 2014).

Much of this research, however, has not reported on a crucially important difference, older problem drinkers are composed of two distinct sub-groups, early- and late-onset. Early-onset problem drinkers have drunk alcohol excessively and problematically throughout their lives (Schonfeld et al., 1987; Zimberg 1978). Late-onset AUD/problem drinking has been reported across a broad time span, ranging from ≤22 years old (Le Strat et al., 2010) at one end of the spectrum, to <60 (Finlayson et al., 1988) at the other end; the most often reported cut-

off age for late-onset is between 40 – 50 years of age (e.g., Wadd et al., 2011; Schonfeld & Dupree, 1991). Cut-off age is determined by an individual's first experience of "problematic alcohol use", which according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013, p. 490) is based on meeting two items on the 11-item DSM-5 AUD diagnostic criteria.

Regardless, the differences between these two sub-groups need to be acknowledged more widely. Two-thirds of older problem drinkers are early-onset and experience problematic drinking at a much younger age and are more likely to engage with alcohol services earlier in life than their late-onset counterparts. In contrast, far less has been reported about older, late-onset problem drinkers; individuals who drank moderately for most of their lives (or not at all), and commence drinking problematically later in life (Droller, 1964; Giordano & Beckham, 1985; Morehead, 1958; Rosin & Glatt, 1971). The stigma, associated with alcohol-related problems can be a barrier preventing late-onset drinkers from seeking treatment and engaging with alcohol services (Keyes et al., 2010; Lancaster et al., 2017; Wadd et al., 2011). In addition, as well as having greater social resources than early-onset drinkers, late-onset drinkers are likely to have fewer alcohol-related problems, less psychiatric comorbidity, and have a better treatment prognosis (Holley-Moore & Beach, 2016: Wadd et al., 2011). Consequentially, there is a need for alcohol practitioners to understand the distinctions between these sub-groups "and the implications for treatment" (Wadd et al., 2011, p. 26).

In common with the general population, as they age, late-onset problem drinkers are increasingly likely to experience late-life events, and stressors, such as losing a partner, retirement, cognitive decline and social isolation. Their reaction to these stressful life events, is increased alcohol consumption (e.g., Dauber et al., 2018; Emiliussen et al., 2017a; Wadd & Papadopoulos, 2014). Some late-onset drinkers have reported a 'meaningless life' as the reason for their excessive drinking (Immonen et al., 2011, p.1169). These older 'reactors' (Christie et

al., 2013, p. 25) are experiencing, what Frankl (2014) has termed a noögenic[2] neurosis, which he conceptualised as an "*existential vacuum*" (p. 61): a feeling of emptiness resulting from a purposeless and meaningless life, which manifests in feelings of apathy and boredom. Framed within Viktor Frankl's (1963) theory of meaning, logotherapy (an existential, spiritual, meaning-centred psychotherapy), the current thesis aims to undertake a thorough investigation of the role that *meaning and purpose in life* (MPL), and other psychosocial characteristics play in the context of late-onset problem drinking and its resolution. The following chapter begins the investigation with a systematic literature review and narrative synthesis of the literature.

Endnote

[1]This is the first instance of the term 'late-onset' appearing in the literature.

[2]In Greek *noögenic* means mind or spirit, and in logotherapy, is viewed as the spiritual aspect of the individual.

CHAPTER TWO

LATE-ONSET PROBLEMATIC DRINKING & ALCOHOL USE DISORDER: A SYSTEMATIC LITERATURE REVIEW & NARRATIVE SYNTHESIS

2.1 INTRODUCTION

Described in detail in the opening chapter, the rising level of alcohol-related harms among older adults continues to have a considerable impact on over-burdened and under-resourced health and social care services (Wadd & Papadopoulos, 2014). Late-onset problem drinkers, constitute "a substantial percentage" of all older problem drinkers (Emiliussen et al., p. 1576, 2017d), yet it is almost a quarter of a century since Johnson (2000) reported that, "The subject of alcoholism in late life has received relatively little attention in the literature." (p. 575). Since Johnson's (2000) epidemiological review of problem drinking in later life, the stigmatizing language used to describe problem drinking (i.e., alcoholism) has arguably, been acknowledged, softened and adapted by many healthcare professionals, academics and researchers working in the subject area (e.g., Kelly et al., 2016; McLaren et al., 2023) and has been transformed into a more inclusive language (i.e., problem drinking) a trend, however, that fluctuates across countries (Martinelli et al., 2020). Little else has changed, however, and unfortunately, there remains a dearth of literature regarding late-onset problem drinking.

Several literature reviews have investigated older adults and problem drinking in a general context in recent years (Bareham et al., 2019; Haighton et al., 2024; Holton et al., 2017; Kelly, et al., 2018a; Kelly, et al., 2018b; Latanioti et al., 2020; Skrzynski & Creswell, 2021), suggesting that the problem of excessive alcohol consumption among older adults is becoming widely recognised and acknowledged as a growing health issue in an ever-increasing aging population (Age UK, 2019), as highlighted in chapter one. The same cannot be said for literature reviews that have focussed on late-onset problem drinking per se, where research is

still wanting, with Emiliussen et al. (2017d) being the only review in recent years that has investigated problem drinking among older adults, specifically through a late-onset lens. That said, many of the findings from the reviews that have reported on problem drinking and older adults in a generic context are equally relevant when applied to the population of late-onset problem drinkers.

For instance, loneliness and isolation, which is prevalent among older individuals (Canham, 2016; Crewdson, 2016), is associated with comorbid at-risk drinking and depression (Schiller et al., 2022). Skrzynski & Creswell's (2021) meta-analysis of 26 articles, which investigated the relationship between solitary drinking and older adults, reported a prevalence rate of between 30-40% among their large sample of older individuals (n = 51,600). Additionally, Skrzynski & Creswell's (2021), reported significant relationships between solitary drinking and the following factors: alcohol consumption, drinking problems and negative reinforcement. Furthermore, males were more likely than their female counterparts to report lone drinking. Similarly, Kelly, et al. (2018a), whose review of 14 qualitative papers reported on effective interventions for harmful alcohol consumption among community dwelling, older adult (>50-years old; n = 1743), reported that higher levels of alcohol consumption were linked to social isolation, as well as illness and bereavement; their investigations also reported a link between alcohol consumption and identity. Bareham et al. (2019), who also reviewed qualitative papers that investigated older drinkers (≥50-years old), were concerned with older adults perception of their own alcohol consumption. Interestingly, they reported that the overarching perception of their review's population of older adults (n = 1419) was that they perceived "themselves as controlled and responsible drinkers" (p. 134). Additionally, the overall sample of older adults in Bareham and colleague's (2019) review, reported they tended to experience difficulties in changing their drinking habits in retirement.

Retirement (Bareham et al., 2019; Emiliussen et al., 2017d; Haighton et al., 2024; Holton et al., 2017; Kelly et al., 2018a; Skrzynski & Creswell, 2021) and to a lesser degree identity (Bareham et al., 2019; Emiliussen et al., 2017d; Kelly et al., 2018a) are recurring themes throughout many of the literature reviews on problem drinking in the context of older adults. That retirement and identity were recurrent themes, suggests that the transition from employment/occupation to retirement may be a challenging time for many older individuals. Indeed, (Kuerbis & Sacco, 2012) literature review focussed solely on '*The impact of retirement on the drinking patterns of older adults*'. Although they did not find a direct relationship between retirement and increases in alcohol consumption per se, they concluded that "transition to retirement and individual attributes, such as having a history of problem drinking, may facilitate or inhibit drinking" (p. 387).

With the exception of Emiliussen et al.'s (2017d) review of older late-onset problem drinkers, it is clear that previous literature reviews have been in the context of older adults and problem drinking from a generic perspective. Moreover, they have predominantly reported on the demographic and psychosocial characteristics of older problem drinkers. In common, with those reviews, the current literature review investigates how the literature has reported the demographic and psychosocial characteristics of older problem drinkers. The focus of the current review is specific and investigates late-onset problem drinkers, a unique cohort within the wider group of older problem drinkers. Additionally, the current review explores how the literature has reported on late-onset problem drinkers from the perspective of the thesis' theoretical framework (i.e., Frankl's logotherapy) and investigates whether MPL plays a role in relation to late-onset problem drinking. By scrutinising the subject's literature, the current review aims to consolidate the existing knowledge on the subject and advance a greater understanding of late-onset problem drinking, which in turn, can inform the direction of the

thesis, future research, and importantly, health and social care policy. The present review then, poses the following questions:

1. What psychosocial characteristics have been reported in relation to people with late-onset AUD/problematic drinking?
2. To what degree has a lack of MPL been reported in relation to people with late-onset AUD/problematic drinking?

2.2 METHOD

The present review aims to investigate how the psychosocial characteristics associated with late-onset AUD/problem drinking in people over 50 years-old have been reported, including the role of MPL. For the purposes of the current review, it is important that the age of onset is specifically defined, as reported above, however, a universal cut-off age for late-onset AUD/problem drinking has yet to be determined. That said, late-onset has most consistently been reported between 40 and 60 years old (e.g., Liberto & Oslin, 1995; McGrath et al., 2005); a time in life when people are increasingly likely to experience meaningful and stressful events (Widner & Zeichner, 1991). Previous reviews used a 20-year range, between 40 and 60 years of age (Liberto & Oslin, 1995; Sorocco & Ferrell, 2006; Widner & Zeichner, 1991), with the most recent review reporting a cut-off age of >50 years old (Emiliussen et al., 2017d). Therefore, for investigative purposes, the present review defined ≥50-years old as an approximate cut-off age for late-onset AUD/problem drinking.

Widely accepted as the gold standard for healthcare reviews (Nobel & Smith, 2018), systematic reviews use pre-defined, easy to replicate methods, that support the researcher to systematically search for evidence. The systematic method is relevant in the context of the current review because it focusses on answering specific questions, within a narrow health-related context (i.e., late-onset AUD/problem drinking and in people over 50). A comprehensive systematic review identifies and investigates key areas of the topic, including

its history, methods, theories, vocabulary, and of course, the leading researchers in the field of enquiry (Randolph, 2009), enabling the researcher to gather sufficient material to produce a wide-ranging narrative synthesis. As such, a literature review is, itself, a substantial piece of research. In the current context, the findings will inform the direction of the thesis. The starting point should be a clearly constructed research question/s to 'identify, select, evaluate and synthesise the available research on the topic' in a methodical and efficient way (Brown et al., 2012, p. S177).

2.2.1 Protocol and search strategy for the literature review

Scoping search

The purpose of the scoping search is manifold. Firstly, similar reviews on the topic can be identified, which can mean having to change review question/s. The scoping search also helps to identify if there is enough available literature to undertake a comprehensive review, or if the topic is saturated. Additionally, by looking at the terminology used in the titles, abstracts and the reference sections of key papers, ideas on key search terms can be formulated. A scoping search was performed on the *title*, *abstract* and *subject*/*topic* fields of five databases, BMC Systematic Reviews, The Cochrane Review Library, Library Plus[1], PsychInfo and Web of Science. In addition, PROSPERO, a review registration database, was searched, to establish if similar reviews had been registered and were in progress. The scoping review showed there were very few papers on the topic (the term *late-onset* was not in usage prior to 1980). The few influential papers that had reported the phenomenon before 1980 (e.g., Droller 1964; Glatt et al., 1978; Rosin & Glatt, 1971, Zimberg, 1974), were using language such as, "heavy drinking in their later life" (Glatt et al., 1978, p. 64). Therefore, a broad timeframe was adopted for the main search, to include studies spanning a 40-year timeframe between 1980 – 2020. Additionally, because late-onset has been defined across a broad age range (25-60), the search terms used, needed to capture the age range specific to the current review (50+). As well as

'late-onset alcoholism' and 'late-onset alcohol use disorder', an appropriate number of synonyms of 'elderly' were employed. The search terms used for the scoping review were:

late onset alcoholism OR late onset alcohol use disorder

AND

elderly OR aged OR older OR elder OR geriatric OR elderly people OR old people OR older people OR senior

Inclusion and exclusion criteria

Inclusion and exclusion criteria are necessary components that help the review to remain focussed on its aims and reduce the risk of bias, because studies are only selected according to pre-determined criteria. Typically, medical, clinical and healthcare-related questions, are formulated within the PICO framework (e.g., Schlosser, et al., 2007). PICO (Population, patient or problem being studied; Intervention; Comparison or control; and Outcome) is commonly used to gather evidence from randomised control trials (RCTs). However, studies on late-onset AUD/problem drinking are mostly of a cross-sectional, comparative nature (i.e., late-onset vs. early-onset). The PICO model, designed for studies framed within purely clinical boundaries, was, therefore, considered inappropriate. The inclusion criteria and exclusion criteria are described in Table 2.1.

Table 2.1.

Study eligibility criteria.

Inclusion Criteria	Exclusion Criteria
Papers investigating, either late-onset alcoholism or late-onset AUD or late-onset problem drinking.	Papers investigating problem drinking in older people in a generic context (i.e., not specifically late-onset).
Papers published between 1980 and 2021.	Papers published before 1980.
All methods (qualitative, quantitative or mixed methods).	Editorials, commentaries, reviews reporting older problem drinking in a general context.
All settings (residential or community-based).	Theses and dissertations.
All cultural or geographical contexts.	Papers not published in English.
Peer-reviewed papers.	Papers not peer-reviewed.

Main search strategy

The scoping search indicated there was a dearth of papers on the topic. As such, a more inclusive and broader approach known as "lumping" was favoured over the narrower approach of "splitting" (e.g., Gotzsche, 2000; Weir et al., 2012). Whereas "splitting" focusses on specificity (i.e., a distinct type of intervention), "lumping" allows for a more general scope of study types, interventions and outcomes. The limited literature on the topic encouraged a diverse search strategy, incorporating several methods. Using free-text search terms and the Boolean parameters AND, OR and quotation marks (" "), the primary searches were conducted on several databases: Library Plus[1], Google Scholar, Proquest, PubMed, Scopus and Web of Science. Table 2.2 lists the search terms used:

Table 2.2.

Search terms used.

Search term 1
"late-onset alcohol use disorder" OR "late-onset alcoholism" OR "late-onset problem drinking"
Search term 2
"late-onset alcohol use disorder" OR "late-onset alcoholism" OR "late-onset problem drinking" AND "the elderly" OR "older adults" OR "old people" OR "senior citizens" OR "baby boomers" OR "people over 50"
Search term 3
"alcohol and the elderly" OR "alcohol and older adults" OR "alcohol and old people" OR "alcohol and senior citizens" OR "alcohol and baby boomers" OR "alcohol and people over 50"

The three search term groups above, were applied systematically to the following fields in each database: *title*, *subject*/*topic*, *abstract*. The *author* field of each of the six databases was searched using the names of the key authors in the area as they became evident. Based on the inclusion and exclusion criteria (Table 2.1), and where database functionality allowed for it, the following limiters were applied: *peer-reviewed journals*; *English language*; *articles*

published between 1980 and 2020. The totals shown for each database (Table 2.3) are the totals of the three search terms combined.

Table 2.3.

Databases searched and number of articles returned.

Library Plus[1] = 425	Google Scholar = 925	Proquest = 91
PubMed = 28	Scopus = 71	Web of Science = 49

2.2.2 Data Screening

Primary screening

The screening strategy followed the process recommended by the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA; Moher et al., 2009) framework (Figure 2.1). Using the databases and search terms outlined above, after removing duplicate studies, the primary search returned 1,595 papers. Based on a title scan, a further 1,514 articles were excluded at the initial screening stage; 81 articles were retained based on title content (e.g., late-onset, late-life, alcohol use, alcohol consumption, older problem drinkers, older adults) and skim reading the papers' abstracts. During initial screening, several seminal papers (12) in the topic area were identified and obtained from other sources (contacting authors; external library requests), increasing the total number of retained papers to 93. The reference sections of these 93 papers were scrutinised, and an iterative process of searching the reference sections of relevant papers (reference harvesting), was undertaken (Table 2.4), yielding a further 42 papers, increasing the number to 135 papers.

Table 2.4.

Reference harvesting — iterative stages.

Iterations	Relevant papers harvested based on title & abstract	Papers kept for final criteria screening stage, after skim reading whole article.
First iteration	28	7
Second iteration	7	2
Third iteration	5	2
Fourth iteration	2	2
Totals	**42**	**12**

Why such a substantial number of relevant papers (42) were not returned during database searches is worthy of discussion. It could be argued that the search strategy was not thorough enough. Although it may partially be the case that the search strategy was not thorough enough, other reasons merit consideration. For example, the technology on many databases is not infallible, and items may not have been comprehensively indexed. Additionally, authors may not have used the appropriate key terms to describe their paper. Because of these technical fallibilities, reference harvesting and hand searches are recommended supplementary search methods After searching for 'late-onset' throughout each paper, a further 70 papers were excluded at this stage (*Appendix 2.1,* lists the papers and provides reasons for rejecting the papers). The remaining 65 papers were scrutinised, 39 of which were excluded at the final screening stage (*Appendix 2.2* lists the papers and provides reasons for rejecting the papers at this final stage). Figure 2.1 describes the screening process.

Appraisal and data extraction

The remaining 26 papers satisfied the inclusion criteria and were scrutinised using the Cohort Checklist of the Critical Appraisal Skills Programme (CASP; 2021)[2]. Using a modified version of the JBI data extraction tool (Lockwood et al., 2020), each of the 26 studies was systematically appraised and scrutinised; comprehensive tables were compiled from the extracted data (*Appendix 2.3*). The main characteristics of the studies are presented in Table

2.5: a). The location and author/s of the studies; b). The aims of the study; c). The study sample/population and context; d). Method of data collection and analysis used; e). Results and key findings; f). Treatments and interventions used and follow-up (if any); g) Study limitations and recommendations. These descriptive data enable researchers to "establish the generalisability of the results" (Munn et al., pp. 49-50). During the data extraction process, both the homogenous and heterogeneous characteristics between studies can be identified, which importantly, informs the grouping of studies in the subsequent narrative synthesis.

2.3 RESULTS

Context of included studies

Population and setting — Of the 26 studies, nine studies described samples of people who were receiving or had received treatment in a residential setting (study nos. 1, 2, 3, 15, 17, 19, 23, 24, 26). Nine studies included people receiving or who had received treatment in outpatient or community settings (study nos. 4, 5, 8, 10, 11, 12, 13, 14, 20, 25). Four studies included people with drinking problems who were or had been in contact with health services, though not in treatment programmes (study nos. 6, 7, 21, 22). The population of one study (no. 9) was a mixture of people who had received treatment as either outpatients or inpatients. The population of two papers (study nos. 16, 18) were a mixture of people who had received treatment in either an inpatient or outpatient setting, and people who had received no treatment.

Nationality, cultural context — Fifteen studies were carried out within the USA, four within Denmark, two within Germany, three within the Netherlands, and two within the UK.

Temporal context — Fourteen studies were undertaken over a nine-year period between 1985 — 1994, and ten were conducted between 2013 — 2019. Only two studies were carried out in the 19-year period between 1994 — 2013 (Schutte et al., 1998; Wetterling et al., 2003).

The defining characteristic of narrative syntheses is the use of text to summarise or "tell the story" of the findings from multiple studies (Popay et al., 2006, p. 5). Two factors support the use of a narrative synthesis. Firstly, a lack of numerical data across the studies, preventing the collection standardised effect sizes. Secondly, if there is methodological heterogeneity across the reviewed papers. While most of the studies are cross-sectional, there are longitudinal and retrospective studies, and three are qualitative. Additionally, outcome measures were inconsistent throughout, e.g., while some studies reported a follow-up outcome measurement, the majority did not. Taking these factors into account, a narrative synthesis is the most appropriate method of presenting the findings.

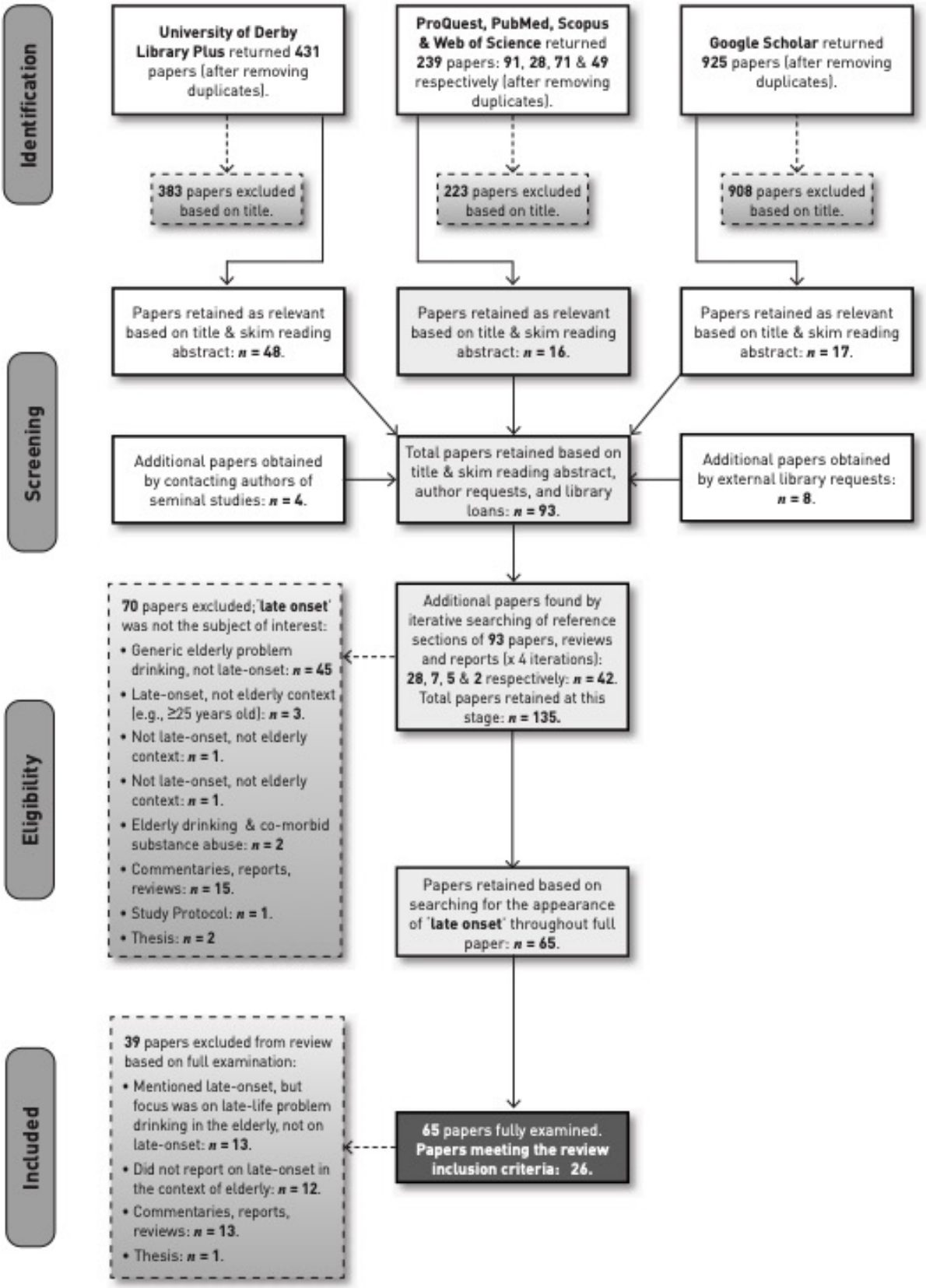


Figure 2.1.

PRISMA flow diagram, adapted from Moher et al. (2009)

Table 2.5. *Summary of the characteristics of papers included in the review. (Acronyms used throughout: alcohol use disorder/s = AUD/s, early-onset = EO, late-onset = LO.)*

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
1†	Adams & Waskel (1991a). USA.	To explore and determine whether MPL was a stressor associated with the onset of problem drinking. To test the hypothesis that there may be a relationship between purpose in life and alcoholism in later life.	Sample size: *n* = 57. Age: ≥60, *m* = 67.6. EO: *n* = 33. Onset of drinking problems before 40 years of age. Quasi-LO: *n* = 20. Onset of drinking problems between 40 and 60 years of age. LO: *n* = 7. Onset of drinking problems after 60 years of age. For the purposes of the study, the Quasi-LO and LO were grouped together. Residential treatment centres setting.	Cross-sectional study. Instruments used: 1. Veterans Alcoholism Screening Test (VAST)*. 2. Purpose in Life Test*. Purpose in Life Test scores analysed and compared. Analysis used: *t* tests were used to make *ad hoc* comparisons.	Purpose in life mean scores: EO: 89.58 (*SD*=19.40). LO: 97.29 (*SD*=18.54). No significant differences between the two groups. Comparisons also made between the groups and previously published purpose in life scores; significant differences were found between the LO group, an EO group (*n* = 38), and a group of non-alcoholic, non-institutionalised older men (n = 38) from an earlier study.	No follow-up. Treatment not described.	All male sample. Institutionalised population. Not randomised. Very small sample. The above factors indicate the results cannot be generalised to a wider community population. Quasi-LO group not controlled for, i.e., too large of an age range (40-60). Secondary diagnosis and severity of drinking problem not controlled for.
2†	Adams & Waskel (1991b). USA.	To determine: 1) Whether the prevalence of men over 60-years old with LO alcoholism in treatment for alcoholism, matched the commonly reported rate of one-third or more alcoholics with LO. The role that common stressors in older age play in LO alcoholism in older adults.	Sample size: *n* = 57. Age: 61-79. Residential treatment centres setting. Questionnaire (unnamed) used to establish onset of alcoholism, defined as: 1. EO: Before 40. 2. Quasi-late (QLO): 40-60. 3. LO: >60.	Cross-sectional study Instruments used: 1. VAST. 2. Stokes/Gordon Stress Scale*. Analysis used: *t* tests were used to make *ad hoc* comparisons.	VAST indicated: LO: *n* = 7 (11%). QLO: *n* = 20 (33%). Combined the two late-onset groups accounted for 44% of the sample. There were no significant differences in stressors between the combined LO group and the EO group.	No follow-up. Treatment not described.	Small, all male sample. Institutionalised population. Not randomised. Above factors indicate results cannot be generalised. Memory concerns about reliable onset of alcoholic drinking. Small sample accounts for the low ratio of LO reported and previously reported rates.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
3[†]	Adams & Waskel (1993). USA.	Based on the premise that LO alcoholism is more about loss of structure than stressful events, the study assessed the differences in social-psychological structures between early- and late-onset alcoholics.	Sample size: *n* = 57. Age: ≥60, *m* = 63.6. EO: *n* = 32. LO: *n* = 28. Residential treatment centres setting.	Cross-sectional study Instruments used: 1. VAST. 2. DPS*. Analysis used: Chi-square tests.	No significant differences between groups for social-psychological structures. The only significant difference was between onset and marital status. LO — less to do with stress than with loss of spouse, who may have regulated older men's drinking.	No follow-up. Treatment not described.	All male sample. Institutionalised population. Not randomised. Very small sample. The above factors indicate the results cannot be generalised to a wider community population. Memory concerns about reliable onset of alcoholic drinking.
4	Atkinson, Tolson, & Turner (1990). USA.	To determine age of onset of problem drinking. To investigate the differences in psychopathological characteristics between onset age of AUD. To investigate the differences in treatment compliance.	Sample size: *n* = 132. Age: ≥60. All-male military veterans. DSM-III diagnosis of AUDs Outpatient treatment programme. For this study, age of onset was determined by self-reports of first instance of problematic alcohol use (social, occupational or legal). EO: ≤40 MLO: 41-59 LO: ≥60 *n*	Longitudinal study. Instruments used: 1. Structured interviews. 2. MMPI*. Analysis used: ANOVAs, Pearson product-moment correlation, and x^2 methods.	Onset age distribution: EO: *n* = 50 (38%) MLO: *n* = 62 (47%) LO: *n* = 20 (15%) In almost 50% onset occurred after 45. Family alcoholism less common in LO, strong association with EO. EO have history of psychopathology compared to LO, who tend to drink as a reaction to late-life events/stressors.	12-month treatment programme comprised weekly group counselling meetings, and abstinence from alcohol/substances. Treatment compliance: No association between onset age and relapses. Higher age of onset associated with better group attendance and treatment completion. Compliance, however, may be due more to age, and social response, than the age of onset.	Implication that late onset drinking was more common than thought of at the time. All male sample. Not randomised. Entire sample were military veterans, which could have been a major contributory factor in their drinking. Additionally, none of the cohort had other comorbid mental disorders; making self-reports questionable.

[†] Although the research aims of papers 1, 2, and 3 differ, the sample, as well as the method of data collection for the papers, are similar. This is because the data for all three papers came from a study that formed the basis of a PhD thesis (Adams, 1990). The original thesis is not included in the review; being a thesis and a non-peer reviewed article it did not meet the review's strict search and inclusion criteria, whereas the subsequent studies in the current review have been published in peer reviewed journals.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
5	Atkinson, Turner, Kofoed, & Tolson (1985). USA.	To report on the differences between EO and LO older alcoholics participating in a special outpatient programme.	Sample size, *n* = 36. Age: 53-76, *m* = 64.5. LO: *n* = 22 (3 females). EO: *n* = 14 (all male). Outpatient treatment programme.	Longitudinal study. Instruments used: MMPI. Analysis used: *t* tests were used.	Onset age of alcoholism and categorisation (i.e., EO or LO) was determined by patient's self-reports of when they first experienced alcohol-related problems. Other areas measured: History of family alcoholism, greater in EOs (EO = 86%, LO = 41%). EO also more likely to have legal problems than LO. Treatment compliance for both groups high.	Twelve-month programme. Total abstinence. Weekly group meetings. The mean attendance rate calculated on 12-months was slightly higher for LOs (EO = 81.9%, LO = 89.1%). However, compliance for both groups was much higher compared to younger alcoholics (i.e., average duration age for all patients is 6 months, with an average attendance rate of (60%).	Small sample. Gender disparity, only 3 females, all LO (8.3% of total sample). The authors believed this to be the first time that family alcoholism data had been used in the context of an older alcoholic cohort.
6	Brennan & Moos (1991). USA.	To determine the prevalence of LO drinking. Compare the characteristics that differentiate LO problem drinkers, EO problem drinkers & non- problem drinkers. A stress and coping framework used to make comparisons between the groups in the study. The prevalence and correlates of help-seeking between the two drinking groups was a consideration.	Sample size: *n* =1,313. Age: 55-68, (*m* = 61.5). *Drinking Problems Index* used to classify participants into the three groups: EO: *n* = 475. LO: *n* = 229. Non-problem drinkers: *n* = 609. Community-dwelling adults, who had recent contact with medical centres.	Cross-sectional study. Participants recruited via telephone calls. Instruments used: 1. HDL*. 2. LISRES*. 3. CRI*. Instruments measured: Alcohol and health-related functioning. Life stressors and social resources. Coping measures. Help-seeking. Analysis used: Duncan multiple range tests; ANOVAs	LO drank less, had fewer alcohol-related problems, felt less isolated, and had fewer falls and accidents, than EO problem drinkers. LO had more supportive life contexts and reported less chronic life stressors than EO. Both drinking groups more likely to seek help for emotional distress, rather than drinking problems.	No follow-up. Treatment not described.	Gender disparity in the overall sample size:- Female: 37.2%. Male: 62.8%. EO: Female 22.3%. Male 77.7%. LO: Female 38.9%. Male 61.1%. Conclusion implied there should be more focus on screening for LO problems in healthcare settings. LO older drinkers exhibit a greater treatment compliance than EO drinkers.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/ Intervention	Limitations/ Implications
7	Brennan, Moos, & Kim (1993). USA.	To explore and investigate gender differences in individual characteristics and life contexts (i.e., substance use, depression, treatment-seeking) of late-life problem drinkers.	Sample size: *n* = 704. Age: 55-65. Female: *n* = 195. Male: *n* = 509. Community-dwelling adults, who had recent contact with medical centres.	Longitudinal study. Instruments used: 1. HDL; 2. RDC*. 3. LISRES. 4. DPI*. Areas measured: a) Substance use and depression. b) Help-seeking efforts. c) Life stressors and social resources. d) Time of onset. Analysis used: ANOVAs; Repeated-measure ANOVAs.	*Substance use and depression:* Higher prevalence of LO among females (46%), than among males (28%). Females more depressed, took more psychoactive meds. *Help-seeking efforts:* Females less likely to seek help for drinking. *Life stressors & social resources:* Males: finance, friends. Females: spouse and extended family.	12-month follow-up. Data-driven, observational study, not treatment-based. Gender differences in life contexts among continuing problem drinkers, roughly the same at follow-up. *Remitted drinkers:* Reduced alcohol consumption (more so for men). No gender differences in help-seeking. Reported more family/ spouse stressors.	Disparity in the overall sample size (i.e., 28% females, compared to 72% males). A more equal gender split would have demonstrated greater validity and made the results more generalisable.
8	Christie, Bamber, Powell, Arrindell, & Pant (2013). UK.	To describe the drinking patterns and characteristics of a sample of older problem drinkers (60+ years) who had been assessed for alcohol treatment, over a period of 20-years.	Sample size: *n* = 585. Age: ≥60, (60-95). Mean age = 65.7. Females: *n* = 225. (38.5%). Males: *n* = 360. (61.5%). This study defines LO problem drinking as beginning >50 years old, referring to them as late-life 'reactors', in response to adverse events in later life. Community-dwelling adults assessed for alcohol treatment in the community.	Retrospective analysis of alcohol treatment assessment data from an NHS Trust database. Instruments used: Socio-demographic and drinking details were obtained from assessment interview with clinical team. No standard measures used. Analysis used: Uni- & bi-variate analyses examined individual variables & gender differences. *t* tests & chi-square tests where appropriate.	Assessments increased over 20-yr. period. Demographic characteristics static. Ethnicity: 94% white. Weekly consumption: *m* = 102.91 units. Daily drinking: 79%. Home drinking: 84%. Solitary drinking: 82%. Length of problem drinking: *m* = 9.7 yrs. Gender differences (41% of females were widowed, compared to 10% of males).	Treatment programmes were not discussed (only baseline assessment data were analysed). Follow up not applicable.	Categorisation of onset at baseline not considered, meaning that average given categorises total sample of older drinkers seeking treatment as LO. Much of the data on the database had been poorly recorded (i.e., psychiatric diagnosis, prescribed medications). Study implications are that most older problem drinkers seeking treatment are LO.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/ Intervention	Limitations/ Implications
9	Dauber, Pogarell, Kraus, & Braun (2018). Germany.	To determine the proportion of older adults with a diagnosis of alcohol use disorder (AUD), in treatment. To determine characteristics (i.e., early- or late-onset). To investigate the efficacy of treatment outcomes. Based on self-reports, this study defines LO problem drinking as drinking problems beginning after 45-years old.	Sample size: n = 10,860. Age: ≥60, m = 64.5. Female: n = 3,771. Male: n = 7.089. Patients aged 60+ entered into treatment programmes: Inpatient: n = 2,262. Outpatient: n = 8,598. EO: n = 4,131, (inpatient: n = 962, outpatient: n = 3,169). LO: n = 3,227, (inpatient: n = 786, outpatient: n = 2,441). **N.B.** Data for age of onset were not available for all of the patients. Thus, the sub-samples of EO and LO do not correspond to sample total.	Cross-sectional study. Data were from patients in addiction care services. (outpatient centres, n = 837, inpatient, n = 206) were held within the treatment centres, thus ensuring uniformity across all data generated, at the start and completion of treatment. Because of structural differences across treatment settings in the German healthcare system (e.g., treatment types) results for outpatient and inpatient environments were reported separately. <u>Analysis used:</u> Descriptive analysis using Microsoft Excel.	Across whole sample, females were slightly older than males. EO patients younger than LO patients. Highest proportion of women were in the LO patients (outpatient: 41.6%, inpatient: 38.4%). LO patients widowed more often than EO patients. Most divorces among EO patients. Mean age of AUD onset for males was 40; females 45. LO patients mean age of AUD onset: Outpatient, m = 54.3. Inpatient, m = 55.2. EO patients mean age of AUD onset: Outpatient, m = 29.8. Inpatient, m = 28.3. AUD duration was longest among EO patients, 34.5 years, compared to 10.5 years among LO.	Low referral rate for older to treatment services from doctors, therapists, family and nursing homes. Evidence suggests higher treatment and abstinence self-efficacy for older people, at least on discharge — approximately 80% of older patients assessed as successful on discharge. Treatment history indicates that AUDs are less severe in LO than in EO patient. No significant differences in treatment outcomes between EO and LO patients. Based on their sociodemographic, disorder- & treatment characteristics, older women and LO patients viewed as a unique cohort in overall demographic.	The authors were cautiously critical of their method of statistical analysis (chi^2) and suggest that perhaps more individualistic data may have given a more sophisticated analysis. Treatment outcome assessment based on the subjectivity of the therapist at the point of discharge.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/ Intervention	Limitations/ Implications
10	Dupree, Broskowski, & Schonfeld (1985). USA.	To investigate the characteristics of LO problem drinkers. To assess and evaluate over a 24-month period, the efficacy of a pilot day treatment programme developed specifically for LO problem drinkers: The Gerontology Alcohol Project (GAP).	Sample size: *n* = 48. Age: ≥55, *m* = 65.9. Females: *n* = 22. Males: *n* = 26. Mean age of LO of problem drinking was 58 years.	Quantitative longitudinal study. Instruments used on admission, discharge and follow-ups included: GAP DP*; GAP PSI*; GAP SSNI*; PARS*; State-Trait Anxiety Inventory*; BDI*; Locus of Control (I-E) Scale*; LSI. Analysis used: ANOVAs were used to make *post hoc* analyses (Fischer's L.S.D. test).	Instruments used at admission and discharge included: GAP Demographic/ Psychosocial assessment. The Brief Psychiatric Rating Scale. At admission: Alcohol not a problem until later life. Physical symptoms due to alcohol abuse: Tremors (56%); blackouts (43.8%); restlessness (52%). Social/personal: All poor social networks. No finance difficulties.	Four behavioural and self-management treatment programmes employed. Outcomes: 24 dropped-out and did not complete the 24-month programme. One client died. 17 reached and maintained their goal of total abstinence.7 reach their goal of 'responsible, limited drinking'. Differences in 'dropouts' and successful graduates noted (i.e., dropouts drank more, had higher depression scores).	The study implied that there are enough LO problem drinkers to warrant specific age-related treatments. Moreover, the study also implies that positive outcomes among LO problem drinkers are good. Although dropout rates a concern and further research suggested.
11°	Emiliussen, Anderson, & Nielson (2017a). Denmark.	Explore and understand the characteristics and motivations of older adults with alcohol problems that lead to entering treatment, and how they understand treatment in the wider context of recovery	Sample size: *n* = 12. Age: 61 - 76, *m* = 68.6 Females: *n* = 5. Males: *n* = 7. Diagnosis of very-late-onset (VLO) AUDs Participants sober at least 2 weeks & various stages of treatment. Previous psychological/ psychiatric treatment: *n* = 3. First time treatment: *n* = 9.	Qualitative study using Interpretative phenomenological analysis (IPA). Data were collected from semi-structured interviews.	Eighteen superordinate themes identified, study reported on four only. 1) Family as pressure structure. 2) Health: a motivator to enter treatment. 3) Self-reliance/ maintaining agency. 4) Ambivalence about treatment. Most common motivating factors to enter treatment were: a) Family pressure; b) Health problems.	Although treatment not mentioned by the authors, the participants mention Motivational Interviewing (MI). The number of sessions ranged between 4-12. The mean number of sessions was 7.5. No follow-up mentioned.	Although participants reported positive treatment outcomes, 6- or 12-month follow-up interviews would have been enlightening. These comments are applicable to the paper below (no.12).

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
12°	Emiliussen, Anderson, & Nielson (2017b). Denmark.	To explore how older adults with AUDs perceive and define their alcohol problems and consider the impact these definitions have on treatment seeking.	Sample size: *n* = 12. Age: 61 - 76, *m* = 68.6 Females: *n* = 5. Males: *n* = 7. Diagnosis of very-late-onset (VLO) AUDs All participants sober for at least two weeks and at various stages of treatment. Previous psychological/ psychiatric treatment: *n* = 3. First time in treatment: *n* = 9.	Qualitative study using IPA complemented by NVivo 10 software. Data collection as above paper (no. 11).	Eighteen superordinate categories identified across all cases, only two reported on: a) Alcohol use b) Alcohol misuse Themes within these main categories were further discussed, including: *Defining misuse of alcohol* and *Control*. The study suggests that older adults seek to avoid the stigmatisation of alcoholism and avoid treatment seeking.	As paper 11 (above).	This paper and the one above (no. 11) are from the same study, therefore, the same limitations apply.
13°	Emiliussen, Anderson, & Nielson (2017c). Denmark.	Investigated why older adult's alcohol problems after 60 years-old.	Sample size: *n* = 12. Age: 61 - 76, *m* = 68.6 Females: *n* = 5. Males: *n* = 7. Diagnosis of very-late-onset (VLO) AUDs All participants sober for at least two weeks and at various stages of treatment. Previous psychological/ psychiatric treatment: *n* = 3. First time in treatment: *n* = 9.	Qualitative study using IPA complemented by NVivo 10 software. were collected from semi-structured interviews. The same 'pilot' process was undertaken as the two papers directly above (no. 11 and no. 12).	Three kinds of VLO drinkers identified, two discussed: *Increasers*: Heavy, drinking before 60 increased and became problematic after 60. *Reaction drinkers*: Hardly drank until after 60, when it became problematic. Findings suggest alcohol as a coping mechanism, driven by a loss of identity & lack of meaning &purpose.	As papers 11 and 12 (above).	This paper and the two above (nos. 11 and 12) are from the same study. Therefore, the same limitations are applicable to this paper. The extra comment below obviously applies to all three papers too. The sample may have been too homogenous, all of the participants were middle or upper-middle class, and had supportive, extended family networks.

° Studies 11, 12, 13 and 14 were sub-studies of the *Elderly Study* (Anderson et al., 2015), an RCT comparing two interventions for people of 60(+) years-old with AUD. The *Elderly Study* used a sample of 1,000 people in numerous locations across three countries, Denmark, Germany and the USA; the four studies herein were conducted in Denmark. Three of them (11, 12 & 13) asked different research questions using the same sample and data from an interpretative phenomenological analysis (IPA) semi-structured interview.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
14°	Emiliussen, Anderson, Nielson, Braun, & Bilberg (2019). Denmark.	Investigated whether choice of treatment goals differed between older people with VLO AUDs (≥60 years-old) and those who experienced early- or mid-life onset (EMO) AUDs.	Sample size: *n* = 341. VLO: *n* = 56. Age: *m* = 68.5. Female = 45%. Male= 55%. EMO: *n* = 205. Age: *m* = 64.3. Females = 37%. Males= 63%. AUD onset unknown: *n* = 80. Results data for this group were not presented in this paper. Treatment centre outpatients.	Cross-sectional study. Participants recruited from an international Elderly Study. Questionnaires used: 1. Thoughts about alcohol abstinence scale*. 2. Form90*. 3. Motivation: Importance, Confidence, Readiness Rulers Worksheet*. 4. MINI International Neuropsychiatric Interview 5th Edition*. Analysis used: Logistic regression applied to chi^2 & Wilcoxon rank-sum test.	Results showed there were significant differences in choice of treatment goals. *Controlled drinking:* VLO group: 32.1%. EMO group: 57.1%. *Total abstinence goal:* VLO group: 10.7%. EMO group: 31.3%. *Temporary abstinence treatment goal:* VLO group: 32.1%. EMO group: 8.2%. Authors hypothesise VLO individuals may find it easier to curtail their drinking than EMO group, who have drunk for longer.	Treatment prior to abstinence/drinking goals not mentioned. No follow-up.	Gender differences not considered in data analysis. No longitudinal data were available, which would have been useful to compare goals with actual outcomes. Authors acknowledge recall bias in relation to participants memory of AUD onset. Participants not random: they were seeking treatment.
15	Finlayson, Hurt, Davis, & Morse (1988). USA.	To investigate the psychiatric and psychosocial features of an older population in an alcohol and drug treatment centre, to determine psychiatric treatment needs.	Sample size at baseline: *n* = 216. Age: 65 - 83, *m* = 69.6. EO: *n* = 122 (56.5%). LO: *n* = 89 (41.5%). Indeterminate: 5 (7%). In this study LO defined as alcohol problems beginning at ≥60 years-old. Inpatients of an alcoholism and drug dependence treatment centre.	Cross-sectional study Instruments used: 1. DCMIII used for diagnostic purposes. 2. MMPI. 3. WAIS*. Analysis used: Chi-square tests. ANOVAs and related *F* ratios.	Later-life events figured more largely in LO than EO. Concern of family and friends was more of a factor in LO than EO.	Twenty- eight-day treatment programme. Treatment followed disease concept model of recovery, and included group therapy, counselling, films and lectures, family involvement and planning for ongoing recovery after discharge. No follow-up data in relation to EO and LO.	Because this study was not randomised or solely interested in EO and LO alcoholism, a disproportionate number of the patients had either comorbid psychiatric/psychological conditions (i.e., drug abuse), or organic neurological disorders (i.e., dementia associated with alcoholism).

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
16	Fitzgerald & Mulford (1992). USA.	To investigate the experiences of older problem drinkers regarding treatment contact discrimination and recovery rate disadvantages, compared to younger problem drinkers. For this study, LO defined by participants' self-reports of at least one of seven items (one of which was driving while intoxicated) occurring at ≥55 years-old.	Sample size at baseline: *n* = 637. Age: 18-54. *n* = 281. (onset not assigned to this younger group). Age: ≥55, *n* = 357. EO: *n* = 201. LO: *n* = 156. ≥55 age group was sub-categorised: Age: 55+, *n* = 278. EO: *n* = 162. LO: *n* = 116. Age: 65+, *n* = 79. EO: *n* = 39. LO: *n* = 40. Community-dwelling individuals, who had been arrested for drinking and driving.	Longitudinal study Baseline interviews carried out by phone contact (*n* = 609) or mail (*n* = 28). <u>Instruments used:</u> ASI*. <u>Analysis used:</u> Chi-square test (with Yates correction), and Kolmogorov-Smirnov (K-S) test.	No evidence to indicate that older adults were discriminated against when seeking treatment. Only significant difference, people over 65 with EO more likely to contact Alcoholics Anonymous (AA).	Treatments: 1. Treatment centre (inpatient/outpatient). 2. AA. 3. Drunk driving school. Follow-up interviews by telephone and mail. *Recovery Rates*: The older (EO and LO) groups reported as high or higher recovery rates than the younger group. This study concluded that older problem drinkers are not discriminated against in the context of treatments access and treatment outcomes.	Gender differences not considered in report. Not a randomised sample. Drunk drivers are more likely to seek or be directed towards treatment. It should be acknowledged that this population may not have been seeking treatment had they not been arrested for drunken driving.
17	Kist, Sandjojo, Kok, & Van den Berg (2014). The Netherlands.	To examine differences in cognitive dysfunction between older alcohol-dependent people with EO, LO or VLO alcohol dependence.	Sample size: *n* = 85. EO: *n* = 27; Age: *m* = 57.7. LO: *n* = 28; Age: *m* = 61.1. VLO: *n* = 30; Age: *m* = 65.6. Inpatients at a detox. unit for older people with a diagnosis of alcohol dependence, who had been abstinent from alcohol for at least three days.	Cross-sectional study. <u>Instruments used:</u> 1. K-SNAP*. 2. TMT*. 3. Stroop Colour Word Test*. <u>Analysis used:</u> ANOVAs and x^2 tests, and ANCOVAs.	The LO and VLO groups reported less years of heavy alcohol consumption compared to EO group. No significant IQ differences between all three groups. However, all three groups tested lower in IQ compared to a non-alcoholic-dependent norm group.	Treatment type/s not mentioned. No follow-up.	Too small a sample to generalise. Questionable validity of cognitive tests in early stages of alcohol withdrawal/recovery. Implications: that the cognitive impairments of LO & VLO older drinkers are similar to EO, who drank for decades, may suggest the negative impact alcohol can have on the ageing brain.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
18	Mulford & Fitzgerald (1992). USA.	To investigate differences between older problem drinkers and younger problem drinkers. To determine if older problem drinkers need special treatment programmes.	Sample size: n = 730. Age: 18-54: n = 323. Age: >55: n = 407; EO, 232; LO, 175. Sample made up of "problem drinkers" who had their driving licences revoked due to driving a motor vehicle while intoxicated (DWI).	Cross-sectional study. Self-reports obtained by interviewing the subjects by phone (mostly) or mail, using a structured interview schedule. The younger problem drinkers were then compared to the older problem drinkers. Instruments used: 1. IAIS* (modified). 2. ASI. Analysis used: Chi-square test (with Yates correction), and K-S test.	Few significant differences ($p \leq 0.01$) between the younger problem drinkers and the combined sub-groups of older problem drinkers. Most significant differences between younger problem drinkers and older EO problem drinkers. Fewest differences between younger problem drinkers and older LO drinkers. ASI indicated LO less likely than EO to meet DSM-III criteria for alcoholism.	Treatment type/s not mentioned. No follow-up. One aim of the study was to determine if there were enough differences between younger and older problem drinkers to justify older specific treatments. The authors found too much heterogeneity between the older sub-groups (EO and LO) to warrant a bespoke treatment for older adult problem drinkers.	Sample not randomised. Sample not typical of an older population (i.e., all fit enough to drive and does not control for health variables). Gender differences not a consideration. Under-diagnosis of alcoholism meant that LO less likely to seek help/treatment.
19	Schonfeld, Dupree, & Merritt (1987). USA.	To investigate and compare the characteristics of older LO problem drinkers and older EO problem drinkers	Sample size: n = 52. EO: n = 26. Females: n = 10. Males: n = 16. Age: m = 61.5. LO: n = 26. Females: n = 10. Males: n = 16. Age: m = 67.6. Outpatients attending a day programme. LO in this study defined as no history of alcohol problems prior to the age of 50.	Cross-sectional study. Instruments used: 1. GAP Drinking Profile. 2. GAP SSNI. 3. BDI*. 4. State-Trait Anxiety Inventory. 5. LSI. Analysis used: t tests were used to compare quantitative variables and chi-square tests compared qualitative variables.	EO withdrawal symptoms much more severe than LO. EO exhibited more depression, anxiety, less life satisfaction than LO. EO abused alcohol more often than LO. EO suffered from more emotional problems than LO. EO younger and more likely to have been treated for alcohol dependence than LO.	Participants were admitted to a day treatment programme, **the Substance Abuse Program for older adults**. Content of programme not mentioned. No follow-up mentioned.	Sample not randomised.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
20	Schonfeld & Dupree (1991). USA.	To investigate and compare the drinking antecedents of EO and LO problem drinkers.	Sample size: *n* = 46. EO: *n* = 23; Females: *n* = 8; Males: *n* = 15; Age: *m* = 65.4. LO: *n* = 23; Females: *n* = 8; Males: *n* = 15; Age: *m* = 65.6. Outpatients attending a day treatment programme. In this study, LO was defined as alcohol problems emerging after the age of 50.	Cross-sectional study. Instruments used: This study used the same instruments as those employed in study no. 19 in this review (Schonfeld et al., 1987), with the addition of one further instrument: PARS. Analysis used: Chi-square tests, two-way ANCOVA and three-way ANOVA.	LO more stable living environment than EO. EO intoxicated more. Age they felt drinking became a problem: EO: *m* = 40.0. LO: *m* = 61.5. Age they were told by others: EO: *m* = 36.1. LO: *m* = 59.9. Prior treatment: EO: *n* = 13; LO: *n* = 9. Antecedents to first drink of day mostly negative emotions: LO, 78%; EO, 60.9%.	Treatment not described. However, LO (*n* = 17) nearly twice as likely to complete treatment than EO (*n* = 10). No follow-up.	Small sample size. Sample not randomised. Gender bias:- Females: 34.7%. Males: 65.3%.
21[#]	Schutte, Brennan, & Moos (1994). USA.	A four-year follow-up study comparing characteristics of stably remitted late-life problem drinkers, non-remitted problem drinkers and non-problem drinkers. Additionally, the study sought to find out if predictors of stable remission differed between LO and EO problem drinkers.	Sample size: *n* = 881. Age: 55-65 at baseline; *m* = 61.5. *n* = 429 problem drinkers at time 1. *n* = 452: non-problem drinkers at time 1. Community-dwelling adults	Longitudinal study. Baseline instruments used for categorisation of EO, LO, and non-problem drinking: DPI. Other instruments used: 1. HDL. 2. LISRES. 3. CRI. Analysis used: Duncan multiple range tests, ANOVAs, ANCOVAs, MANCOVAs & *t* tests.	Baseline predictors of remission: *To-be-remitted problem drinkers* more likely to seek help from mental health professionals than *to-be-non-remitted problem drinkers*[‡]. *To-be-remitted problem drinkers* more likely to receive spousal and friend approval of drinking behaviour than *to-be-non-remitted problem drinkers*.	Four-year follow-up: *n* = 305: problem drinkers at time 1, continued to be problem drinkers at 1- & 4-year follow-up. *n* = 124: problem drinkers at time 1, were stably remitted at 1- & 4-year follow-up. *n* = 452: non-problem drinkers at time 1, still identified as non-problem drinkers at 1- & 4-year follow-up.	Not an ethnically diverse population (mostly white). Limited educational status: sample was mostly highly educated.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
22[#]	Schutte, Brennan, & Moos (1998). USA.	To identify the risk factors associated with the development of LO problem drinking in older adults. This was achieved by investigating non-problem older drinkers over a 7-year period and comparing those who had developed LO problem drinking with those who were still non-problem drinkers.	Sample size: n = 687 at baseline (274 subjects included in the analysis for all stages: baseline, 1-, 4- and 7-year follow-up). Age: 55-65 at baseline; m = 61.5. Community-dwelling, adults who had been attending a health care facility. Those who had never consumed alcohol and those who drank alcohol less than once a week were excluded.	Quantitative longitudinal study. Instruments used: 1. DPI. 2. HDL. 3. LISRES. 4. CRI. 5. Inventory to Diagnose Depression-Lifetime Version (IDDL)*. Analysis used: ANOVAs.	Baseline drinking behaviours predictors of LO drinking. At baseline: LO drinking problems drank more than non-problem drinkers. LO had greater friend approval of drinking. LO smoked more. LO had less acute medical conditions. LO more of a history of depression, than non-problem drinkers <50.	1, 4 and 7-year follow-up showed drinking problems or LO at: 1-year: n = 35. 4-year: n = 31. 7-year: n = 11. Total LO at 7-year follow-up: n = 77. Non-problem drinkers at -year follow-up: n = 197. Instruments used at follow-up: DPI; Alcohol Dependence Scale.	Not an ethnically diverse population (mostly white). Gender differences not considered. The results from the study identify the risk factors associated with LO problem drinking to inform interventions to help older adults from developing drinking problems.
23	Van den Berg, Hermes, van den Brink, Blanken, Kist, & Kok (2014). The Netherlands.	The study sought to investigate the physical, mental and social functioning characteristics of older inpatients, in order to determine age of onset of alcohol dependent drinking.	Sample size: n = 157. Age: ≥ 50; m = 61.5. Female = 38.0%. Male = 62.0%. The subjects were inpatients in a detoxification ward, specialising in older patients (≥ 50). All had received a DSM-IV diagnosis of alcohol dependence.	Cross-sectional study. Cross-sectional study. Demographic data were obtained from the patients electronic records. Variable data were harvested from semi-structured interviews addressed 7 variables associated with substance abuse Instruments used: Interview schedule used Europ-ASI*. Analysis used: ANOVAs and Pearson's x^2 tests.	Categories identified: EO: n = 47. LO: n = 50. VLO n = 60. Older patients had more mental, physical and social problems. Severity dependent on the age of onset. EO patients had more long-term medical problems; more likely to have suicidal thoughts than LO. VLO had as many comorbidities as the other two groups.	Treatment type/s not mentioned. No follow-up.	Sample not randomised. Sample not typical of older population (i.e., all subjects were treatment-seeking individuals).

[‡] The terms 'to-be-remitted' and to-be-non-remitted' are used in a retrospective context and refer to remitted and non-remitted drinkers at baseline. That is, the behaviours displayed at baseline that were predictors of their subsequent remission status, i.e., 'to be'.

[#] These two papers used data from the same longitudinal study.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
24	Van Montfoort-De Rave, De Weert-Van Oene, Beurmanjer, & Koekkoek (2017). The Netherlands.	The study sought to investigate discrimination reported by older outpatients, and in particular older LO alcohol dependent patients, who sought help in a treatment centre, and compare the results to problems experienced by an adult age group.	Sample: *n* = 1,914. Four Groups: 1 Adults group: *n* = 1,471; Age: 24-55. 2 EO: *n* = 78. 3 MLO: *n* = 136. 4 LO: *n* = 229. Age for 2, 3 & 4: ≥55. Onset age defined as problems with alcohol: EO: <25. MLO: 25-45. LO: >45. Addiction treatment centre patients.	Cross-sectional study, which explored the subjects' data, held on the database of an addiction treatment centre. Instruments used: MATE*. MATE is based on the WHO biopsychosocial model of health. Analysis used: ANCOVAs.	LO group experience less severe problems in several areas compared to EO, MLO and the adult groups. LO are just as likely to develop the same severity of alcohol problems as EO and MLO peers, in a short period of time. LO group used more medication for physical illnesses, had more diseases and experienced more confusion.	Treatment type/s not mentioned. No follow-up.	Sample not randomised. Authors imply that comorbid needs of older adults not being met by current treatment, means that LO are at risk of dropping out of treatment, and recommends bespoke treatment programmes for this sub-group.
25	Wadd, Lapworth, Sullivan, Forrester & Galvani (2011). UK.	To develop guidelines for the most efficacious strategies and treatment pathways for older problem drinkers.	Sample size: *n* = 26 Age: 50-73 Female: *n* = 6 Male: *n* = 20 The exact breakdown of EO and LO was not reported. Participants were receiving treatment for their alcohol problems at substance misuse treatment services, who specifically deliver for older adults (non-residential).	Qualitative. Data collected from: A synthesis of relevant literature. 1-to-1 interviews and focus groups with 15 practitioners and managers of services). 1-to-1 interviews with 11 older problem drinkers: 3 women, 8 men, aged 55-73. Focus group with 15 older problem drinkers: 3 women, 12 men, aged over 50. Analysis used: Thematic analysis.	Increased alcohol use in LO problem drinkers was a coping mechanism, associated with multiple late-life events and losses (e.g., retirement, loss of a partner, becoming a caregiver) and other stressors (e.g., chronic pain, financial concerns). The paper concluded that there are many barriers to effective treatment (e.g., underdiagnosis in primary care of LO problem drinkers).	Primary interventions: • 1-to-1 counselling. • CBT • MET • MI • SMART recovery. • Social Behaviour & Network Therapy Suggests older adults adhere to treatment more than younger people. The report, recommends that the heterogeneity of the cohort of older drinkers, means that treatment needs to be tailored individually.	Sample were all in specialist alcohol services. Cohort was not randomly selected but were chosen by staff working in services. Interviews/focus group took place at services and did not account for those older adults who may find it difficult to leave their home (for various reasons) from participating.

No.	Paper and study location	Aims	Sample/Context	Method of data collection/analysis	Results/Key Findings	Follow-up, Treatment/Intervention	Limitations/ Implications
26	Wetterling, Veltrup, John, & Driessen (2003). Germany.	To explore whether LO alcoholics (problem drinking commencing after the age of 45) differed from EO alcoholics (problem drinking commencing before the age of 25).	Sample size: *n* = 268. Females: *n* = 72. Males: *n* = 196. Age: *m* = 41.6 ± 9.5 Three Groups (based on self-report of onset): 1. Onset <25; Age: *m* = 32.2 ± 7.9. 2. Onset 25-45. 3. Onset ≥ 45; Age: *m* = 54.9 ± 4.8. The subjects were patients in a hospital ward specialising in detoxification.	Longitudinal study. Instruments used: 1. CIDI*. 2. Drinking/treatment histories, alcohol-related conditions, psychosocial domains assessed using the German Society on Addiction Research & Therapy guidelines. 3. (ICD-10*). Analysis used: ANOVAs and chi-square tests.	Alcohol dependence criteria diagnosed in 94.1% of the EO group, compared to 62.2% in the LO group. Preoccupation with drinking, inability to control drinking was greater in EO group. EO group more at risk of lifetime psychiatric comorbidity, than LO. LO group reported fewer detoxifications and lower alcohol consumption.	Treatment type/s not mentioned. Follow-up on abstinence self-efficacy at 6- and 12-months. LO exhibited a higher rate of abstinence self-efficacy at 12-month follow-up.	Details of follow-up study published elsewhere, however, the subjects lost during follow-ups, were rated as 'relapsers', which is just an assumption and not supported by evidence. Tendency of recall bias associated with self-reports.

Key for abbreviations used in tables.

AA = Alcoholics Anonymous; **ASI** = Alcohol Stages Index; **AUD** = Alcohol use disorder; **BDI** = Beck Depression Inventory; **CIDI** = Composite International Diagnostic Interview; **CRI** = Coping Responses Inventory; **DPI** = Drinking Practices Survey; **DPS** = The Drinking Practices Survey; **EMO** = Early- or mid-life onset; EO = Early-onset; **Europ-ASI** = European version of the Addiction Severity Index; **GAP** = Gerontology Alcohol Project; **GAP DP** = Drinking Profile; **GAP PSI** = Personal Stress Inventory; **GAP SSNI** = Social Support Network Inventory; **HDL** = Health and Daily Living Form; **IAIS** = Iowa Alcoholic Intake Schedule; **ICD-10** = International Classification of diseases 10th revision; **K-SNAP** = Kaufman-Short Neuropsychological Assessment Procedure; **LISRES** = Life Stressors and Social Resources Inventory; **LO** = Late-onset; **LSI** = Life Satisfaction Inventory; **MATE** = Measurements of the Addiction for Triage and Evaluation; **MET** = Motivational Enhancement Therapy; **MI** = Motivational Interviewing; **MLO** = Mid-life late-onset; **MMPI** = Minnesota Multiphasic Personal Inventory; **PARS** = Personal Adjustment and Rolls Skills; **QLO** = Quasi late-onset; **RDC** = Research Diagnostic Criteria; **TMT** =Trail Making Test; **VAST** =Veterans Alcoholism Screening Test; **VLO** = Very late-onset; **WAIS** = Wechsler Adult Intelligence Scale.

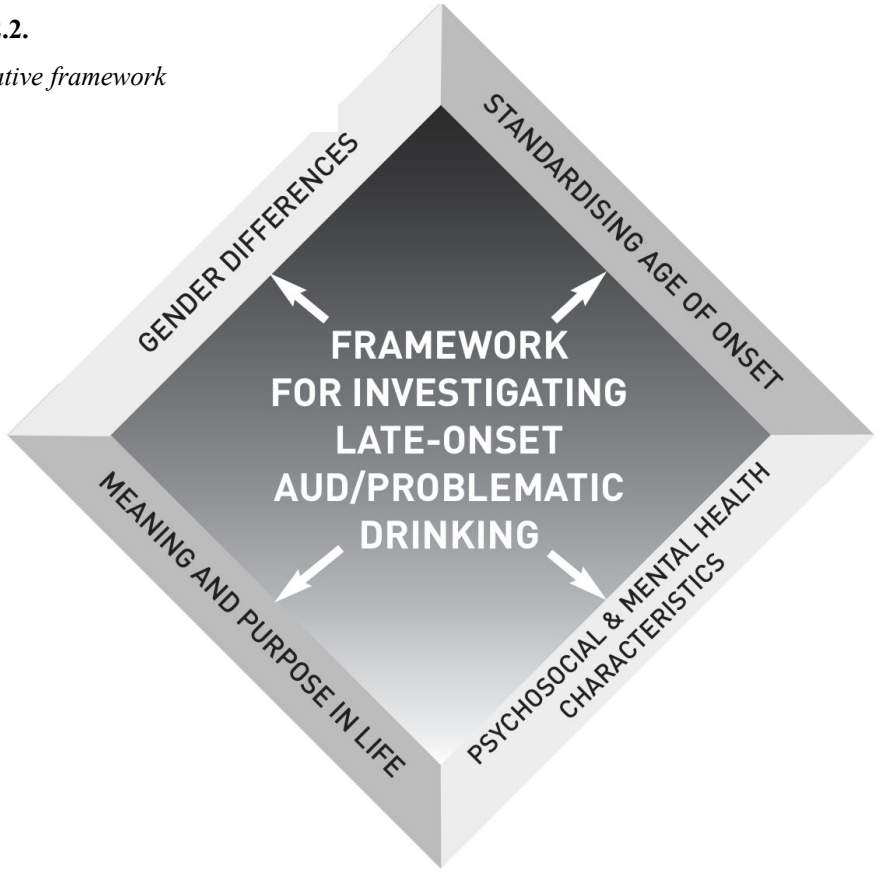
*** For a list of instruments/measures and references see *Appendix 2.4*.**

2.4 A NARRATIVE SYNTHESIS OF THE LITERATURE REVIEW'S FINDINGS

Investigative framework

The current review uses an investigative framework comprised of four defining characteristics to present a narrative synthesis of the literature review's findings: *standardising age of onset*; *gender differences*; *psychosocial and mental health characteristics* and finally, MPL.

Figure 2.2.
Investigative framework



2.4.1 Towards a universal cut-off age for late-onset AUD/problem drinking

Many researchers in the current review (e.g., Christie et al., 2013; Schonfeld et al., 1987) agree that one-third of all older problem drinkers are late-onset "reactors" (Christie et al., 2013, p. 24). Although the DSM-V (American Psychiatric Association, 2013), does not recognise late-onset as a sub-group within its AUD diagnostic criteria, it does state that "perhaps 10%" of all individuals diagnosed with AUD "have later onset" (p.494). However, it can be difficult to detect late-onset AUD/problem drinking in older people. Stigmatisation associated with

alcohol problems means that many older adults have great difficulty in accepting their drinking is problematic and avoid seeking treatment (Hammarlund et al., 2018; Wadd et al., 2011), which affects the individual, the NHS and social care. Additionally, alcohol-related presentations are often mistaken for common, age-related problems (e.g., falls, confusion, depression, etc.), or it may simply be that clinicians are unaware of the problem. Indeed, it has been suggested that "It is important for physicians to inquire about the occurrence of major life events such as retirement or loss of a spouse and to examine the patient's style of coping, including the use of alcohol." (Finlayson et al., 1988, p. 767).

Therefore, it is important for clinicians and other health and social care professionals to understand, a) what the risk factors for late-onset drinking are, and b) approximately when onset is likely to emerge. However, there are considerable differences in how the cut-off age for late-onset has been reported, and it is difficult to predict when late-life events (e.g., bereavement, retirement, social isolation[3], etc.), thought by many to be risk factors for late-onset drinking, are likely to occur. By investigating the disparity in how the cut-off age for late-onset problem drinking has been reported, the present review can move a step closer to a standardised definition of the age when late-onset problem drinking is likely to become evident, thereby informing health and social care professionals and others who are interested in the well-being of this vulnerable population.

Late-onset cut-off age viewed as early as >40

Two studies in the review estimated the cut-off age at the lower end of the current 20-year range (40 – 60), categorising late-onset as beginning after 40 years. The first of these, Atkinson et al. (1985), reported on the differences between early- and late-onset older adult alcoholics[2]. They based their cut-off age for late-onset on the participants' self-reports of when they first experienced alcohol-related problems in one of four areas: legal (e.g., being arrested),

occupation (e.g., dismissal from work), social/family (e.g., marriage breakdown) and medical/health (e.g., treatment for an alcohol problem).

Wadd et al. (2011) similarly determined the cut-off age for late-onset as 40+ years old. Their qualitative research (n = 26) was part of a larger report, to "develop guidelines on what strategies and treatment approaches work best with older drinkers" (p.3). Wadd and colleagues' (2011) cut-off age for late onset problem drinking was based on a review of epidemiology, research, and treatment by Widner and Zeichner (1991), who had reported that late-onset "alcohol abusers are likely to have started drinking heavily after the age of 40" (p. 9). Unlike Atkinson et al. (1985), Wadd et al. (2011) did not report on either the differences between early- and late-onset problem drinkers or the participants' self-reports of the first occurrences of problematic alcohol consumption. Five years after their 1985 study, Atkinson et al. (1990) determined the cut-off age to be 20 years later than their earlier estimate.

Age of onset conceptualised as a trichotomous variable

In common with their earlier study, Atkinson and colleagues (1990) used the participants' self-reports of the first occurrence of problematic alcohol use, to determine age of onset. However, rather than view age of onset as a dichotomous variable (early versus late-onset), Atkinson et al.'s (1990) study contextualised age of onset as a trichotomous variable: early- (≤40 years old), midlife- (41–59 years old) and late-onset (≥60 years old). Twenty participants, from an all-male sample aged 60 or older (m age = 67.1) were assigned to the late-onset group. When analysed, the relationship between the three age variables were found to be significant to the point that "far exceeds chance" (Atkinson et al., 1990, p. 575). Seven more studies in the current review similarly used a trichotomous variable to characterise age of onset (Adams & Waskel, 1991a, 1991b, 1993; Kist et al., 2014; Van den Berg et al., 2104; Van Montfoort-De Rave et al., 2017; Wetterling et al., 2003).

The three Adams and Waskel (1991a; 1991b; 1993) studies harvested data from an earlier project (Adams, 1990) and sample (n = 60). The studies used identical classifications to define onset ages of alcohol dependence[4]. The temporal taxonomy used to characterise the three onset categories, however, differed slightly from those used by Atkinson et al. (1990); the standard, polar classifications of early- and late-onset were unchanged, but the third intermediary category, midlife-onset, was classified as quasi-late-onset. Apart from Atkinson's et al.'s (1990) early-onset age of <40, the onset-ages also differed, with quasi-late- being 40 – 60 years old, and late-onset being >60. A modified version of the *Veteran's Alcoholism Screening Test* (VAST; Magruder-Habib et al., 1982) was used to determine the onset ages of the participants.

Kist et al. (2014) and Van den Berg et al. (2104) shared the same temporal taxonomies and onset age variables proposed by Wetterling et al. (2003): early- (<25 years old), late- (25 – 45 years old) and very-late-onset (>45 years old). Assigning participants to onset groups in both studies was based on their answers to a question in the *European Addiction Severity Index* (Europ-ASI; Kokkevi & Hartgers, 1995): "at what age did you first start regularly drinking five or more alcoholic beverages a day?" (Van den Berg et al., 2104, p. 227). The mean age of the onset of problems in the very-late-onset groups in both studies was 58.9 and 56.6 years old respectively, considerably later than Wetterling and colleagues' (2003) cut-off mark of >45 years old. Van Montfoort-De Rave et al. (2017) also followed the three onset classifications proposed by Wetterling et al. (2003). However, because Wetterling et al. (2003) used the same temporal taxonomy to characterise onset as Atkinson et al. (1990): early-, mid- and late-onset, the age ranges varied considerably. For example, Van Montfoort-De Rave et al.'s (2017) late-onset cut-off age of >45, was much closer to Atkinson's et al.'s (1990) midlife-onset of between 41 – 59 years old, than Atkinson's and colleague's (1990) late-onset classification of ≥60 years old. Wetterling et al.'s (2003) onset classifications, which informed a number of later

studies in the current review, were themselves influenced by earlier research (Atkinson, 1990; Schuckit et al.,1976)[5].

Wetterling's et al.'s (2003) also used a trichotomous variable. Their study, however, used the two main polar classifications only: early- (<25) and late-onset (>45). The middle onset group (25 – 44 years old) was not assigned an adjective (i.e., middle), rather the group was referred to as "Group A 25/45", used as a comparative variable to support investigating the differences between early- and late-onset alcoholics. Onset group allocation was based on self-reports of when harmful drinking first occurred. The mean age of the onset of harmful drinking for the late-onset group was 44.4 years old. Dauber et al. (2018) is the final study to use a late-onset cut-off age of >45 years old.

Age of onset conceptualised as a dichotomous variable

Dauber et al. (2018) investigated late-onset drinking using a simple dichotomous variable: early onset being <45 years old, and late-onset ≥45 years old, using data from a large sample of inpatients and outpatients (n = 10,860), aged 60 and over who had received diagnoses of AUD (partially based on self-reports). The mean age of onset for the late-onset group (n = 3,337) was 54.75 years old. The remaining 15 studies, similarly to Dauber and colleagues (2018), used a straightforward dichotomous variable. Five studies determined the cut-off age as ≥50 years old (Brennan & Moos, 1991; Christie et al., 2013; Dupree et al., 1984; Schonfeld et al., 1987; Schonfeld & Dupree, 1991). Brennan and Moos (1991) compared the characteristics of older problem drinkers aged between 55 – 65 years old (m age = 61.5). Onset classification was determined by a combination of the participants' self-reports and their scores on the 17-item *Drinking Problems Index* (DPI; Finney et al., 1991). Individuals who reported one or more current alcohol-related problems, but no problems two years prior to baseline assessment, and whose problems had emerged after the age of 50 were classified as late-onset.

The mean age of the late-onset cohort was 61.7; the mean age of the onset of problematic drinking was not reported.

Christie et al.'s (2013) study analysed a 20-year dataset of patients (>60 years old) who had been assessed for treatment by a Community Alcohol Team (CAT). The late-onset cut-off age was based on investigations by McGrath et al. (2005), who reported that "The late-onset drinkers usually develop after the age of fifty" (p. 229). The onset of problematic drinking classification was determined by the participants' self-reports (including drinking diaries) and showed that most of the sample (n = 585) were late-onset reactors. The mean age of the sample was 65.7 years old, and the average self-perceived duration of problem drinking was 9.7 years, meaning that problematic drinking in the cohort began in their mid-50s, thus confirming late-onset as >50 years old.

The Gerontology Alcohol Project

Dupree et al. (1984), was part of a larger project, the *Gerontology Alcohol Project* (GAP; Dupree et al., 1982), a pilot day-treatment programme developed for older adults. Dupree and colleagues (1984) investigated late-onset problem drinkers only (n = 48), whom they defined as "individuals aged 55 and over whose onset of an abusive alcohol pattern occurred at age 50 or later" (p. 510). The age of onset of problematic drinking was based on self-reports. The mean age of onset was 58.0 years old. Two other studies in the review had links with the GAP. The first was presented at the Annual Convention of the American Psychological Association (APA). Schonfeld and colleagues' (1987) investigated the differences between early- and late-onset "elderly alcohol abusers" (p. 5). The study's participants (n = 26 early- and n = 26 late-onset) also attended the GAP outpatient treatment programme. Participants were categorised as late-onset problem drinkers if they had no history of problematic alcohol use or treatment prior to the age of 50 years old. The mean age for late-onset was 62.8 years old.

The third study in the review (Schonfeld and Dupree, 1991) used similar methods, including the GAP-DP instruments (Dupree & Schonfeld, 1986) and the same cut-off age for late-onset (>50 years old) to conduct a retrospective comparative cohort study of the drinking antecedents of early- and late-onset older adults problem drinkers. Records of problem drinkers aged ≥60 years old who had taken part in the GAP were reviewed. Participants (n = 46; *m age* = 65.5) were categorised as late-onset if, prior to the age of 50: they had no history of alcohol problems, had not entered treatment and had never attended AA. This study highlights the perceptual differences between the late-onset participants and those who knew them. That is, the mean age at which the late-onset participants believed their problem began was 61.5 (*SD* ± 4.92), whereas the mean age they were told they had a problem by someone else was 59.9 (*SD* ± 5.04). The next five studies approximated the cut-off age for late-onset as ≥55 years old.

Late-onset viewed as beginning at ≥55

Brennan et al. (1993), investigated gender differences in late-life problem drinkers (n = 659) but did not define a definite cut-off age for late-onset per se, rather individuals who reported experiencing problems with alcohol in the two years prior to baseline assessment but none before were classified as late-onset; participants were aged between 55 – 65 years old (*m* age = 61.0). The next two studies, Fitzgerald and Mulford (1992) and Mulford and Fitzgerald (1992), both compared the experiences of older adults problem drinkers with their younger counterparts. The methods and samples of both studies were similar (n = 637 and n = 730 respectively). The older participants in both studies were dichotomised into two sub-groups (≥55 and ≥65) no significant differences were found and the groups were deemed to be heterogeneous. Late-onset was defined as ≥55 years old. The *Alcohol Stages Index* (ASI; Mulford, 1977) was used to identify age of onset. Participants were classified as late-onset if they self-reported at least one of six alcohol-related items occurring at the age of 55 years old

or later (i.e., age first experienced any problems due to drinking). Neither study reported a mean age for late-onset.

The final two studies in this category (late-onset as ≥55 years old), (Schutte et al., 1994, 1998) were sub-studies from a larger longitudinal project. Both studies followed the same cohort of older adult drinkers at 1- and 4-year follow-up, and 7-year follow-up respectively. The project identified characteristics associated with late-onset problem drinking and recovery, based on participants recruited between 55 and 65 years old. Using the DPI, classification of late-onset problem drinking was based on self-reports of experiencing one or more drinking-related problems in the two years prior to baseline, but none before that. The cut-off age for late-onset drinking in both studies was set at ≥55 years old. Self-reports were again employed at the follow-up periods, to identify late-onset problem drinking. Mean age for late-onset was not reported in either study. The final five studies in the review, similarly to Adams and Waskel (1991a, 1991b, 1993) estimated the cut-off age for late-onset at the high end of the 20-year range, ≥60 years old.

Late-onset viewed as beginning at ≥60

Finlayson et al. (1988) investigated the psychiatric and psychosocial characteristics of older alcohol dependent[3] patients in an alcohol and drug service, aged between 65 and 83 years old, (*m* age = 69.6; *n* = 216). Onset categorisation depended on reports from patients or family members and friends, about life events thought to "have had a temporal relationship with either the inception or exacerbation of problem drinking" (Finlayson et al., 1988, p. 762). Consequently, 89 late-onset alcoholic patients were identified. Data of the life events of both onset categories were analysed and statistically significant differences were found between early- and late-onset older alcohol dependent patients ($p = < 0.001$).

The final four studies, Emiliussen et al. (2017a, 2017b, 2017c, 2019), are sub-studies of the *Elderly Study* (Andersen et al., 2015): a randomised clinical trial (RCT) carried out in

multiple sites, in Denmark, Germany and the USA. In common with Kist et al. (2014) and Van den Berg et al. (2014), Emiliussen et al. (2017a, 2017b, 2017c, 2019) characterised their participants as very-late-onset AUD. However, at ≥45 years old, Kist et al. (2014) and Van den Berg et al. (2014) had determined their cut-off age for very-late-onset to be 15 years earlier than the ≥60 years old chosen by Emiliussen et al. (2017a, 2017c, 2017d, 2019). Three of the Emiliussen et al. (2017a, 2017b, 2017c) studies used qualitative methods, sharing the same sample (n = 12) and data. Participants in all three studies had received diagnoses of AUD according to the DSM-V (APA, 2013). The cut-off age for very-late-onset AUD was determined by self-reports of when alcohol problems were first experienced.

Using quantitative methods, the fourth study, Emiliussen et al. (2019), also analysed data from the *Elderly Study* (Andersen et al., 2015) to compare the differences in treatment goals between participants with early- or mid-age onset (EMO) AUD (<60) and those with very-late-onset AUD (≥60); this study viewed EMO as a homogenous group. Participants (n = 341) were classified as very-late-onset if they reported experiencing two or more symptoms present in the DSM-V (APA, 2013) criteria for AUD diagnosis, after the age of 60 years old. Fifty-six participants (m age = 68.5) were classified as very-late-onset (m age of very-late-onset = 64.1 years old).

Table 2.6.

How age of late-onset problem drinking/AUD has been determined and reported by the studies in the review.

Study		Late-onset as defined by author/s	Measure used to define late-onset	Mean age/range first drinking problem reported	Mean age/range of the late-onset cohort in study
1	Adams & Waskel (1991a)	>60	Veteran's Alcohol Screening Test (VAST; Magruder-Habib et al., 1982).	Not reported	*m* = 67.6
2	Adams & Waskel (1991b)	>60	VAST.	Not reported	61 – 79
3	Adams & Waskel (1993)	>60	VAST.	Not reported	*m* = 64.6
4	Atkinson et al. (1990)	≥60	Determined by self-report of first occurrence of alcohol-related problems.	Not reported	*m* = 67.1
5	Atkinson et al. (1985)	>40	Determined by self-report of first occurrence of alcohol-related problems.	*m* = 51.0	*m* = 61.9
6	Brennan & Moos (1991)	>50	Responses (self-report) to Drinking Problem Index (DPI; Finney et al., 1991).	Not reported	*m* = 61.7
7	Brennan et al. (1993)	>55	Responses (self-report) to DPI.	Not reported	*m* = 61.0
8	Christie et al. (2013)	>50	Self-report, including drinking diaries.	55 – 60	*m* = 65.7
9	Dauber et al. (2018)	>45	Diagnosis of AUD (based on self-report) + Wetterling et al. (2003) classification.	*m* = 54.75	>60
10	Dupree et al. (1984)	≥50	Self-report, using GAP Drinking Profile. (GAP-DP; Dupree & Schonfeld, 1986).	*m* = 58.0	*m* = 65.9
11	Emiliussen et al. (2017a)	>60	Determined by self-report of first occurrence of alcohol-related problems.	Not reported	*m* = 68.6
12	Emiliussen et al. (2017b)	>60	Determined by self-report of first occurrence of alcohol-related problems.	Not reported	*m* = 68.6
13	Emiliussen et al. (2017c)	>60	Determined by self-report of first occurrence of alcohol-related problems.	Not reported	*m* = 68.6
14	Emiliussen et al. (2019)	>60	Determined by self-report of first occurrence of alcohol-related problems.	*m* = 64.1	*m* = 68.6
15	Finlayson et al. (1988)	≥60	Self-report of the time that life events triggered problem drinking.	Not reported	*m* = 69.6
16	Fitzgerald & Mulford (1992)	≥55	Self-report of one of 6 drinking-related adverse events occurring at 55 or later.	Not reported	≥55
17	Kist et al. (2014)	≥45	Self-report of drinking ≥5 drinks a day + Wetterling et al. (2003) classification.	*m* = 58.9	*m* = 65.6
18	Mulford & Fitzgerald (1992)	≥55	Self-report of one of 6 drinking-related adverse events occurring at 55 or later.	Not reported	≥55
19	Schonfeld et al. (1987)	≥50	Self-report using the GAP-DP.	*m* = 62.8	*m* = 67.6
20	Schonfeld & Dupree (1991)	≥50	Self-report using the GAP-DP.	*m* = 59.9	*m* = 65.6
21	Schutte et al. (1994)	≥55	Responses (self-report) to DPI.	Not reported	55 – 65
22	Schutte et al. (1998)	≥55	Responses (self-report) to DPI.	Not reported	*m* = 61.3
23	Van den Berg et al. (2014)	≥45	Self-report of drinking ≥5 drinks a day + Wetterling et al. (2003) classification.	*m* = 56.6	*m* = 65.2
24	Van Montfoort-De Rave et al. (2017)	≥45	Self-report using MATE (Schippers et al., 2010) + Wetterling et al. (2003) classif.	Not reported	*m* = 61.6
25	Wadd et al. (2011)	>40	Based on classification of late-onset in earlier review (Widner & Zeichner, 1991).	Not reported	55 – 65
26	Wetterling et al. (2003)	>45	Determined by self-report of first occurrence of alcohol-related problems.	*m* = 44.4	*m* = 54.9

Table 2.7.

How the studies in the review categorise onset ages of problem drinking/AUD.

Study		Categorisation of onset ages				Study specific categorisations
1	Adams & Waskel (1991a)	EO: <40	QLO: 40 – 60	LO: >60	–	QLO and LO groups were combined to form one LO group.
2	Adams & Waskel (1991b)	EO: <40	QLO: 40 – 60	LO: >60	–	QLO and LO groups were combined to form one LO group.
3	Adams & Waskel (1993)	EO: <40	QLO: 40 – 60	LO: >60	–	QLO and LO groups were combined to form one LO group.
4	Atkinson et al. (1990)	EO: <40	MLO: 41 – 59	LO: ≥60	–	Categorised MLO group, as well as EO and LO groups.
5	Atkinson et al. (1985)	EO: <40	–	LO: >40	–	
6	Brennan & Moos (1991)	EO: ≤50	–	LO: >50	–	
7	Brennan et al. (1993)	–	–	LO: >55	–	Categorised LO only (investigated gender differences).
8	Christie et al. (2013)	–	–	LO: >55	–	Categorised LO only.
9	Dauber et al. (2018)	EO: <45	–	LO: ≥45	–	
10	Dupree et al. (1984)	EO: <50	–	LO: ≥50	–	
11	Emiliussen, et al. (2017a)	–	–	–	VLO: ≥60	Categorised VLO only.
12	Emiliussen et al. (2017b)	–	–	–	VLO: ≥60	Categorised VLO only.
13	Emiliussen et al. (2017c)	–	–	–	VLO: ≥60	Categorised VLO only.
14	Emiliussen et al. (2019)	–	EMO: <60	–	VLO: ≥60	Categorised early-midlife onset much later in life than other studies.
15	Finlayson et al. (1998)	EO: <60	–	LO: ≥60	–	
16	Fitzgerald & Mulford (1992)	EO: <55	–	LO: ≥55	–	
17	Kist et al. (2014)	EO: <25	–	LO: 25 – 45	VLO: ≥45	Categorised onset age in all groups much earlier than other studies.
18	Mulford & Fitzgerald (1992)	EO: <55	–	LO: ≥55	–	
19	Schonfeld et al. (1987)	EO: ≤50	–	LO: ≥50	–	
20	Schonfeld & Dupree (1991)	EO: ≤50	–	LO: ≥50	–	
21	Schutte et al. (1994)	–	–	LO: ≥55	–	Categorised LO only.
22	Schutte et al. (1998)	–	–	LO: ≥55	–	Categorised LO only.
23	Van den Berg et al. (2014)	EO: <25	–	LO: 25 – 45	VLO: ≥45	Categorised onset age in all groups much earlier than other studies.
24	Van Montfoort-De Rave et al. (2017)	EO: <25	MLO: 25 – 45	LO: >45	–	Categorised MLO group, as well as EO and LO groups.
25	Wadd et al. (2011)	EO: <40	–	LO: >40	–	
26	Wetterling et al. (2003)	EO: <25	–	LO: >45	–	

Key for abbreviations used in tables 2.6 and 2.7

AUD = Alcohol Use Disorder; **DPI** = Drinking Problem Index; **EMO** = Early or mid-age onset; **EO** = Early-onset; **GAP-DP** = Gerontology Alcohol Project Drinking Profile; **LO** = Late-onset; **MLO** = Midlife-onset; **MATE** = Measurements of the Addiction for Triage and Evaluation; **QLO** = Quasi-late-onset **VAST** = Veteran's Alcohol Screening Test; **VLO** = Very-late-onset.

2.4.2 Gender differences

It has become increasingly common for women to drink more heavily as they grow older (e.g., Epstein, et al., 2007; Gell et al., 2015). According to the NHS (2016), 16 percent of women in England are drinking more than the recommended guidelines (14 units of alcohol a week), the highest prevalence (24%) being among women aged 55 to 64 (the approximate age of late-onset problem drinking). Moreover, the rate of female alcohol-related NHS hospital admissions increased by more than 30 percent in the years between 2008/09 and 2014/15 (ONS, 2016). Additionally, women are more at risk than men of being adversely affected by alcohol, and as they age, their vulnerability to gender-specific risk factors associated with excessive alcohol consumption increases (Epstein et al., 2007; Al-Otaiba et al., 2012).

Liberto & Oslin's (1995) review of late-onset alcoholism, found a higher proportion of women among late-onset drinkers (vs. late-onset men) compared to early-onset women drinkers (vs. early-onset men). Such gender differences indicate that late-onset drinkers are not a homogenous group, therefore, it is important to identify biopsychosocial differences. From a psychological and social perspective, for example, because women tend to outlive their husband or partner, they are at greater risk of experiencing loneliness and depression (Blow & Barry, 2002). Biologically, women metabolise alcohol at a much slower rate than men and have higher levels of ethyl alcohol concentration in their blood (Cowart & Sutherland, 1995), meaning they are more at-risk from the adverse physiological consequences of excessive alcohol consumption (Epstein et al., 2007; Frezza et al., 1990). Such biological dynamics are compounded, as changes in ethanol metabolism become more concentrated in the blood with age (Cederbaum, 2012). Older adults are likely to be taking more prescription medications too, creating the additional risk of harmful interactions between pharmaceuticals and alcohol (Meier & Seitz, 2008). The complexity of biopsychosocial problems means there is a risk of late-onset individuals also presenting with problems other than alcohol.

There is a strong link between older adults, at-risk drinking and comorbid affective disorders such as depression (Age Concern, 2007; Brennan et al., 2016; Rao, 2019), although whether gender contributes in any way is unclear. For example, it has been suggested that because women tend to experience bereavement earlier than men, they are more prone to depression and increased alcohol use (e.g., Blow & Barry, 2002). In contrast, it has been argued that the perception that women are more likely to receive a dual diagnosis than men, reflects "a sociocultural bias" (Edwards et al., 2002, p. 290). Furthermore, among heavy drinkers aged 50 and over, women are less likely than men to report problem drinking (Drummond et al., 2016; Gell et al., 2015), because they tend to feel greater shame and guilt and are more affected by the stigma associated with alcohol misuse (Lisansky Gomberg, 1988). Such behavioural factors are likely to reinforce denial of a drinking problem and create barriers to asking for help (Pretorius et al., 2009). Women, therefore, are more reluctant than men to accept they have a problem and seek treatment (Blow & Barry, 2002; Green, 2006; Pretorius et al., 2009).

Paradoxically, women who engage with treatment have good outcomes (Al-Otaiba et al., 2012; Blow & Barry, 2000; Satre, et al., 2004; Satre, et al., 2007). It has been suggested, however, that to encourage more older women to take up treatment, alternative approaches need to be considered (Cummings et al., 2006), including bespoke programmes that are "sensitive to gender" (RCPSYCH, 2018, p. 86). As they age, many older women are increasingly likely to be in contact with health and social care services. A greater awareness of gender differences will assist professionals working in health and social care settings to better screen their older patients/clients and improve the efficacy of detecting alcohol-related problems. This section then, investigates how gender differences have been reported and the predictive role gender plays in late-onset drinking, and in seeking help and treatment. That said, only 11 of the 26 papers in the current review reported gender differences (Table 2.8).

There are a greater proportion of late-onset women drinkers (vs. late-onset men) compared to early onset women drinkers (vs. early-onset men).

Van Montfoort-De Rave et al. (2017) found a high prevalence of women late-onset drinkers. Van Montfoort-De Rave and colleagues (2017) analysed a large sample of alcohol-dependent patients (n = 1942) who they categorised into four subgroups: an adult group (patients aged between 24 -55) and three older adult groups of patients aged ≥50, whose onset was either early (onset <25 years old), medium (onset 25-45 years old) or late (onset >45 years old). They found there was a much higher proportion of women vs men in the late-onset AD category (42.8%) compared to the other three categories (combined m = 26.3%). Van Montfoort-De Rave et al. (2017) findings consistent with those of earlier studies on older drinking in general (e.g., Blow & Barry, 2000) suggest that the risk of women developing problematic drinking increases with advancing age.

Brennan and Moos' (1991) compared functioning, life context and the help-seeking behaviours of late-onset (n = 229), early-onset (n = 475) and non-problem drinkers (n = 609); recruited from medical centres. There was an even gender split (50.1% women) among the non-problem group. However, there was a stark contrast between the early- and late-onset groups, with a greater proportion of women (38.9%) in the late-onset group, compared to the early-onset group (22.3%). Additionally, the high prevalence of co-morbid alcohol misuse and mood disorders reported by Brennan and Moos (1991), was greater among women participants, meaning that women were more likely than men to seek help from mental health professionals. Furthermore, women felt more stigmatised than men and were less likely to acknowledge their problems were alcohol-related, viewing them instead as mental or emotional problems.

Late-onset women are more depressed and experience more mental and emotional problems than late-onset men.

Brennan and colleagues' (1993) longitudinal study investigated gender differences in older problem drinkers, in the context of individual characteristics and three life contexts (depression, substance use, treatment-seeking). The large sample (*n* = 659; 183 females and 476 males; *m* age = 61) had been in contact with two medical centres for a variety of issues. In common with Brennan and Moos (1991), there was a greater prevalence of late-onset problem drinking among women than men: at baseline, 46 percent of women, compared to 28 percent of men, reported that their problem drinking had only started in the previous two years. However, they consumed less alcohol and experienced less drinking-related problems than men. Women were more depressed than men and took more psychoactive medications. Also, in common with Brennan and Moos (1991), women were more likely than men to seek help from mental health services. At the one-year follow-up, among continuing problem drinkers, there were no changes in drinking behaviours in the context of gender differences, men still experienced more drinking-related problems. However, compared to men, women were more depressed, took more anti-depressant medications, and were more likely to seek help for mental and emotional problems.

Typically, late-onset women are older than late-onset men and tend to drink alone.

The sample (*n* = 585) for Christie et al.'s (2013) study of "late-onset reactors" (p. 25), were of older adults who had been assessed for alcohol treatment in the community. The cohort consisted of 225 females (38.5%) and 360 males (61.5%). Daily alcohol consumption was based on drinking diaries. There were statistically significant gender differences for age, employment and marital status: late-onset women were older and are more likely to be retired than late-onset men (73% and 57% respectively). Reflecting current knowledge about later-life cohabitation, late-onset men were also more likely to be married or cohabiting (57%) than

women (44%). Christie and colleagues (2013) described the profile of the average late-onset, older female drinker at baseline assessment, as a 67-year-old, daily spirit/wine drinker, who drank alone at home, to cope with loneliness, anxiety and depression. In comparison, their profile of the typical male late-onset problem drinker, was that of a 65-year-old daily spirit/beer drinker, who also drank alone at home to cope with anxiety, but unlike women, was either a habitual drinker or alcohol-dependent.

In common with Christie et al. (2013), Dauber et al. (2018) found that women problem drinkers were likely to be older; this finding was based on an extremely large sample (n = 10,860; m age = 64.5), before categorisation into early- and late-onset. Dauber and colleagues (2018) harvested data from the German addiction care system (n = 837 inpatient centres, n = 206 outpatient centres), and included patients aged >60, who had received a diagnosis of AUD, and had entered treatment programmes among 3,227 late-onset patients. Overall, the early-onset cohort was younger than the late-onset cohort, with women accounting for 25% of early-onset patients. In contrast, in common with many of the other studies (i.e., Schutte et al, 1994; Van Montfoort-De Rave et al., 2017), the proportion of women in the late-onset cohort was much larger (41.6% late-onset inpatients and 38.4% late-onset outpatients). According to the authors, this large difference can be explained by the higher proportion of women in this age group in the general population.

Additionally, in common with another of Christie et al.'s (2013) findings, late-onset women were more likely to be retired. Again, in accordance with what is already known, Dauber and colleagues (2018) found that late-onset women were more likely to be widowed and living alone than late-onset men. The authors believe this may explain why women develop AUD/problem drinking later in life, to cope with ensuing loneliness after the loss of a spouse/partner or of children leaving home. Importantly, Dauber et al. (2018) point out that the higher proportion of women in their treatment sample of older adult patients is the opposite of

the gender distribution likely to be found in the general population, in which the probability of receiving a diagnosis for AUD is three times higher among men.

Women are likely to experience more alcohol-related stigma than men.

One factor that probably contributes to the gender disparity of AUD diagnoses noted by Dauber et al. (2018), is how stigma around drinking alcohol affects women and men differently regarding their perceptions of being judged by others, something highlighted by Wadd et al. (2011). Wadd and colleagues' (2011) report on older problem drinkers using qualitative methods (i.e., focus groups and interviews). As well as older people receiving treatment for their alcohol problems ($n = 26$), substance misuse practitioners were interviewed. Practitioners suggested that the stigma and shame associated with problem drinking is likely to have a greater impact on women than men and may also act as a barrier that prevents women from seeking treatment.

Late-onset women drinkers are more likely to achieve remission from problem drinking.

The two Schutte et al. (1994, 1998) studies are sub-studies of a seven-year longitudinal project, one of which investigated gender differences. Schutte et al. (1994) reported on the differences between three groups of older adult drinkers: non-problem drinkers, remitted (abstinent) late-onset drinkers, and non-remitted problem drinkers. They found that although the three groups were "demographically similar" at baseline, there were more women in the non-problem group and the group that later achieved remission (remitted late-onset drinkers), compared to the non-remitted group, who were still drinking problematically at four-year follow-up (Schutte et al., 1994, p. 838). Schutte and colleagues' findings highlight two gender differences. Firstly, they suggest that women are more likely than men to achieve abstinence. Additionally, in common with several studies in the current review (i.e., Brennan & Moos, 1991; Brennan et al., 1993; Christie et al., 2013), they found that the high prevalence of women among late-onset drinkers

compared to women among early-onset drinkers (42% vs. 24% respectively), lends support to the notion that the risk of excessive drinking in women, increases with age.

The Gerontology Alcohol Project (GAP) and gender differences.

The GAP (Dupree et al., 1984), self-management treatment programme was developed specifically for older, late-onset problem drinkers. Although significant differences were reported, Dupree et al. (1984) did not discuss gender differences in detail. Their sample of late-onset drinkers (n = 48) had an even gender mix (females: n = 22, males: n = 26). The first significant gender difference showed that women were more likely than men to drink at home alone. Additionally, more women sought professional support for their emotional problems compared to men. These differences concur with similar findings in other papers (see Table 2.9). Two other studies in the present review have close links with the GAP programme (i.e., Schonfeld et al., 1987; Schonfeld & Dupree 1991), however, only one reported gender differences. Schonfeld and Dupree (1991) investigated the differences in antecedents to drinking between early- and late-onset problem drinkers, finding gender differences in the context of depression. Late-onset men reported experiencing less depression than both early-onset women and early-onset men; late-onset women also suffered less from depression than early-onset men. Schonfeld and Dupree (1991), however, did not compare depression scores between late-onset women and late-onset men. The next four studies (discussed in the section, 'defining age of onset') are sub-studies of a common project.

The Elderly Study.

The four sub-studies of the *Elderly Study* (Andersen et al., 2015), did not directly report gender differences, although gender differences are implicit in two of the studies (Emiliussen et al., 2017a, 2017b). Firstly, Emiliussen et al. (2017a) acknowledge that other researchers have found gender-specific motivations for seeking treatment (Grosso et al., 2013; Share et al.,

2004). Emiliussen et al. (2017b) investigated how older individuals define problem drinking and the implications this has in the context of seeking treatment. Five women participants in the study (females: $n = 5$, males: $n = 7$) each attended more than eleven treatment sessions, compared to an average of less than four sessions, for the seven men.

Significant findings but no major gender differences reported.

Finlayson et al. (1988) examined the records of 216 older adult patients who had been treated for alcoholism, to determine the prevalence of dual psychiatric and affective disorders. Two gender differences were found, unfortunately, the authors do not specify the exact nature of these. Adams and Waskel (1991a) compared scores from the Purpose-In-Life Test (Crumbaugh, 1968; Crumbaugh & Maholick, 1964) between the early- and late-onset cohorts in their study ($n = 60$); no significant differences were found. Post hoc comparisons were also made between the late-onset cohort in Adams and Waskel's (1991a) study and groups from two earlier studies, an early-onset, mixed gender group (Crumbaugh's, 1968), and a study of 20 non-alcoholic, non-institutionalised older men (Meier & Edwards, 1974). Significant differences were found between the two earlier groups and the late-onset cohort in Adams and Waskel's (1991a) paper, but the authors did not report if gender was a contributory factor in the significant differences they found.

Table 2.8.

How gender differences have been reported in the context of late-onset drinking.

Study		Summary of investigating and reporting of gender differences	Gender differences investigated
1	Adams & Waskel (1991a)	All male sample. Post hoc comparison with mixed-gender group from another study but gender not a primary consideration.	✓
2	Adams & Waskel (1991b)	All male sample. Gender differences not reported/considered.	x
3	Adams & Waskel (1993)	All male sample. Gender differences not reported/considered.	x
4	Atkinson et al. (1990)	All male sample. Gender differences not reported/considered.	x
5	Atkinson et al. (1985)	20 late-onset male subjects, 3 late-onset female subjects. Gender differences not reported/considered.	x
6	Brennan & Moos (1991)	Large mixed sample (*n* = 1,313), female 38.9%, male 61.1%. Gender differences investigated/reported.	✓
7	Brennan et al. (1993)	Large mixed sample (*n* = 659), female (*n* = 183), male (*n* = 476). Gender differences investigated/reported.	✓
8	Christie et al. (2013)	Large mixed sample (*n* = 585), female (*n* = 225), male (*n* = 360). Gender differences investigated/reported.	✓
9	Dauber et al. (2018)	Extremely large sample (*n* = 10, 860), female (*n* = 3,771), male (*n* = 7,089). Gender differences investigated/reported.	✓
10	Dupree et al. (1984)	Mixed sample, female (*n* = 22), male (*n* = 26). Gender differences reported, but only a minor consideration	✓
11	Emiliussen, et al. (2017a)	Mixed sample (*n* = 12), female (*n* = 5), male (*n* = 7). Qualitative study. Gender differences not reported/considered.	x
12	Emiliussen et al. (2017b)	Mixed sample (*n* = 12), female (*n* = 5), male (*n* = 7). Qualitative study. Gender differences not reported/considered.	x
13	Emiliussen et al. (2017c)	Mixed sample (*n* = 12), female (*n* = 5), male (*n* = 7). Qualitative study. Gender differences not reported/considered.	x
14	Emiliussen et al. (2019)	Mixed sample (*n* = 341), female (*n* = 41%), male (*n* = 59%). Qualitative study. Gender differences not reported/considered.	x
15	Finlayson et al. (1988)	Mixed sample (*n* = 216). Gender totals not reported. Gender differences investigated/reported.	✓
16	Fitzgerald & Mulford (1992)	Large mixed sample (*n* = 637). Total participants for each gender not reported. Gender differences not reported/considered.	x
17	Kist et al. (2014)	Mixed sample (*n* = 85), female (*n* = 32), male (*n* = 53). Gender differences not reported/considered.	x
18	Mulford & Fitzgerald (1992)	Large mixed sample (*n* = 730). Total participants for each gender not reported. Gender differences not reported/considered.	x
19	Schonfeld et al. (1987)	Mixed sample, (n = 52), female (*n* = 20), male (*n* = 32). Gender differences not reported/considered.	x
20	Schonfeld & Dupree (1991)	Mixed sample, (n = 46), female (*n* = 16), male (*n* = 30). Gender differences not reported/considered.	✓
21	Schutte et al. (1994)	Large mixed sample (*n* = 881). Total participants for each gender not reported. Gender differences investigated/reported.	✓
22	Schutte et al. (1998)	Large mixed sample (*n* = 687). Total participants for each gender not reported. Gender differences not reported/considered.	x
23	Van den Berg et al. (2014)	Mixed sample (*n* = 157), female (*n* = 38%), male (*n* = 62%). Gender differences not reported/considered.	x
24	Van Montfoort-De Rave et al. (2017)	Large mixed sample (*n* = 1,942), female (*n* = 28%), male (*n* = 72%). Gender differences investigated/reported.	✓
25	Wadd et al. (2011)	Mixed sample (*n* = 26), female (*n* = 6), male (*n* = 20). Gender differences investigated/reported.	✓
26	Wetterling et al. (2003)	Mixed sample (*n* = 268), female (*n* = 72), male (*n* = 196). Gender differences not reported/considered.	x

Table 2.9.

Common findings in gender differences across studies.

Finding	**Studies with findings in common.**
Solitary home drinking as the primary drinking location for late-onset women.	Christie et al. (2013); Dupree et al. (1984).
Late-onset women older than late-onset men.	Christie et al. (2013); Dauber et al. (2018).
Late-onset women more likely to be retired compared to late-onset men.	Christie et al. (2013); Dauber et al. (2018).
Greater percentage of women among late-onset problem drinkers compared to early-onset problem drinkers	Brennan and Moos (1991); Brennan et al. (1993); Christie et al. (2013); Dauber et al. (2018); Schutte et al. (1994); Van Montfoort-De Rave et al. (2017).
Late-onset women were likely to be more depressed than late-onset men and take more anti-depressant medications.	Christie et al. (2013); Brennan et al. (1993).
Late-onset women more likely to seek help from mental health professionals for emotional problems.	Brennan and Moos (1991); Brennan et al. (1993); Dupree et al. (1984).
Women are more likely to be affected by the stigma associated with excessive alcohol use.	Brennan and Moos (1991); Wadd et al. (2011).

2.4.3 Psychosocial and mental health characteristics associated with late-onset AUD/ problem drinking

As already noted, (e.g., McGrath et al., 2005), late-onset drinkers are a distinct cohort who constitute one-third of older individuals with drinking problems. Typically, late-onset problem drinkers tend to have greater psychological stability and social support (i.e., family, friends) than their early-onset counterparts, who, due to many more years of excessive alcohol consumption, than late-onset drinkers, have accumulated more somatic (Cargiulo, 2007; Luca et al., 2021; Stickel et al., 2017), psychological (Atkinson et al., 1990; RCPSYCH, 2018; van den Berg et al., 2014) and social problems (Kuperman et al., 2005; Liberto et al., 1995; McGue et al., 2001). Nonetheless, as people grow older, they are increasingly likely to experience late-life stressors, which are considerable risk factors to an individual's somatic, psychological and social well-being. Indeed, there is a strong correlation between chronic late-life stressors and alcohol misuse (Brennan & Moos, 1990; Moos et al., 2010).

One of the most common events to manifest later in life, is a decline in physical health, accompanied by chronic pain, which is associated with alcohol misuse (RCPSYCH, 2018), and many older people use alcohol to cope with pain (Moos et al., 2010). Moreover, there is a strong association between pain and chronic psychological conditions, like depression and anxiety (Gerrits at al., 2015). Older people with affective disorders, for example, have higher rates of alcohol misuse than those without poor mental health (RCPSYCH, 2018), highlighting the prevalence of dual diagnoses in this population. Physical disability is another risk factor associated with depression later in life. The accompanying deterioration in physical, and sometimes cognitive and psychological functionality, are risk factors for depressive disorders in late life, leading to loss of independence and agency and promoting negative feelings (Bruce, 2002) and "feelings of worthlessness" (p. 179). Furthermore, older people with negative self-

perceptions are more likely to drink excessively (Villiers-Tuthill et al., 2106). Many of the stress-provoking events that occur in later life, however, are social.

For some older people, retirement impacts considerably on their drinking behaviour (Bamberger, 2014; Keurbis & Sacco, 2012). Two factors supporting this hypothesis (in the UK and the West generally), are the normalisation of drinking alcohol and its ease of availability (McGrath et al., 2005; Wadd et al., 2011). Additionally, many retired individuals have more disposable income and more spare time in which to drink (Zins et al., 2011). This hypothesis only holds true for individuals with a higher socioeconomic status. Brennan et al. (2010) found that socioeconomic status, along with health and problem-drinking histories, were better predictors of older adults' drinking trajectories, than retirement per se. Furthermore, for many individuals who live on their own, the decline in social capital that often follows retirement, triggers loneliness and social isolation (e.g., Widner & Zeichner), high risk factors for alcohol misuse (Le et al., 2021). A UK survey of 857 adults aged over 65 (Scriminger, cited in Christie et al., 2013), found that 13% (approximately one in eight) drank more after retirement; reasons given for increasing alcohol consumption, included depression (19%) and bereavement (13%).

The loss of a spouse/partner or loved one is, undoubtedly, one of life's most stressful events, and is most likely to occur later in life, and is a major psychosocial risk factor for late-onset AUD/problem drinking (e.g., Kuerbis et al., 2014; RCPSYCH, 2018; Shaw & Palattiyil, 2008). Like retirement, bereavement affects other "life stressors", like loneliness and social isolation (Giordano & Beckham, 1985, p. 69), depression and anxiety (Pilling et al., 2012). Although women are more likely to experience the consequences of loss sooner than men (as discussed in the previous section), men are susceptible to them too (Byrne et al., 1999; Pilling et al., 2012).

This section focuses on how late-life stressors, and other psychosocial characteristics have been reported in the literature. The high prevalence of psychiatric comorbidity found in

this population (Rao, 2011, 219; Rao et al., 2016; Rao et al., 2021; RCPSYCH, 2018), means that the complex relationship that exists between the psychosocial characteristics and mental health of late-onset drinkers (Bruce, 2002; Emiliussen et al., 2017d; Shaw & Palattiyil, 2008; Ward et al., 2008; WHO, 2020), warrant investigation too. A greater awareness of the complex characteristics associated with late-onset problematic drinking, can help health and social care professionals to better understand the problems of an ever-increasing (ONS, 2021b) number of older problematic drinkers in the UK, a population referred to as *invisible addicts*, because their problems are not being addressed in national policy (RCPSYCH 2018).

A complex relationship: alcohol misuse and poor mental health

The previous section highlighted that late-onset women drinkers are more likely to be diagnosed with a comorbid psychiatric disorder than men are. Nevertheless, there is a high prevalence rate of psychiatric comorbidity among late-onset problem drinkers generally. For instance, Dupree et al. (1984) reported that the drinking antecedents for two-thirds of the subjects in their investigation were, being at home (67%), being alone (67%) and negative mood (75%), hallmarks of a socially isolated existence (Kobayashi et al., 2018). Dupree and colleagues (1984) employed a battery of psychometric tests and questionnaires[6]. Half of the original cohort who did not complete the programme had higher depression scores than the half who did complete the programme, and who had achieved and maintained their goals, highlighting again, the complicated relationship between alcohol misuse and poor mental health.

Two further papers in the current review found that negative mood states (i.e., depression and loneliness) were antecedents and reliable predictors of late-onset drinking (Schonfeld et al., 1987; Schonfeld & Dupree, 1991). In common with the early-onset cohorts in both studies, late-onset drinkers tended to drink daily. However, early-onset drinkers suffered more from depression and anxiety than their late-onset counterparts. In the same

context (i.e., depression as a predictor late-onset drinking), Schutte et al.'s (1994, 1998) papers, which investigated the risk factors associated with the development of late-onset problem drinking, are extremely informative. These studies followed a large sample (n = 687) of older adults over seven years (m age = 61.5 at baseline), with the former (Schutte et al., 1994) presenting findings at one- and four-year follow-up, and the latter (Schutte et al., 1998) at the end of the seven-year project. 274 of the participants were non-problem drinkers at baseline, but 77 of them reported drinking problems (late-onset) at one or more follow-ups (1, 4, or 7 years). At baseline, Schutte and colleagues (1994, 1998) reported that, compared to stable non-problem drinkers, those who were later classified as late-onset problem drinkers were more likely to have suffered from depression; concluding that affective disorder, and the way the subjects in their studies reacted to stressors, were the biggest baseline predictors of late-onset problem drinking.

Continuing the trend of psychiatric comorbidity in late-onset drinkers, Brennan and Moos (1991) and Brennan et al. (1993) compared a large sample (n =1,313) of three cohorts of older people (early- and late-onset problem drinkers and non-problem drinkers). Both studies found that the early- and late-onset problem drinkers were more likely to be depressed than non-problem drinkers. The late-onset cohort in both studies also had poorer physical health and took more mood-altering medications (e.g., anti-depressants) than non-problem drinkers. Finlayson et al. (1988) reported similar comorbid negative states among early- and late-onset inpatients in an alcoholism and drug dependence treatment centre (n = 216). Finlayson and colleagues (1988) found that many of their patients' psychiatric comorbidities were not limited to depression and anxiety and included organic brain syndrome (25%) and atypical organic brain syndrome (19%). Unfortunately, separate figures for early- and late-onset were not reported. Cognitive impairment was also the focus of Kist et al.'s (2014) investigations.

Kist et al. (2014) investigated differences in cognitive dysfunction between early- and late-onset problem drinkers using neuropsychological tests[1] to evaluate cognitive functioning. Although the late-onset cohort had fewer years of heavy alcohol consumption than the early-onset group, neurological assessments showed there were no significant differences in cognitive functioning between the two cohorts. Both cohorts, however, performed poorly compared to a non-alcohol dependent control group. Kist and colleagues (2014) findings suggest that, regardless of the age of onset, all alcohol dependent older people may have a degree of cognitive impairment. Importantly, their findings highlight the negative impact alcohol has on the cognitive functioning of the ageing brain, even among those individuals who only begin to misuse alcohol later in life. Kist et al. (2014) recommended that cognitive assessments should be standard procedure in all treatment centres.

Van den Berg et al. (2014) investigated the physical, mental and social functioning characteristics of older adult inpatients (n = 157; m age 65.2). They found that a substantial proportion of patients across all three cohorts (early-, late- and very-late-onset) had comorbid mental health conditions. Suicidal thoughts were more prevalent in the early- and very-late-onset cohorts (21.7% and 16.7% respectively), compared to the late-onset cohort (4.1%). The high rate of suicidal thoughts in the early-onset cohort is understandable, considering the number of years of excessive drinking the cohort was exposed to (m age of onset = 19.2). More recently, Dauber et al.'s (2018) study found that nine percent of older outpatients had a dual-diagnosis of a mental health disorder and AUD. In the inpatient group, comorbidity was almost five times higher (42.1%). That said, Wetterling et al. (2003) found that late-onset drinkers are less susceptible to psychiatric comorbidity than early-onset problem drinkers.

Retirement as a life stressor

Retirement is a considerable risk factor for late-onset drinking. For example, 63 percent of the overall sample (n = 585) of older adults (60+) in Christie et al.'s (2013) study were retired.

That said, most retired people do not drink to excess, and it is more likely that those retirees who begin to drink problematically, use alcohol as a stress-coping mechanism, rather than a time filler. Brennan and Moos (1991) for instance, found that late-onset drinkers were less likely to cope with late-life stressors than their non-problem drinking counterparts; a phenomenon they viewed as "avoidance coping strategies" (p. 1140), more commonly referred to as denial. In a similar vein, 29 percent of the late-onset cohort in Finlayson et al.'s (1988) study, cited retirement as a major reason for drinking excessively. Furthermore, Finlayson and colleagues (1988) reported a significant difference ($p < 0.01$) between early- and late-onset drinkers, in the effect that life stressors had on the alcohol consumption of each group, with alcohol misuse and the onset of AUD increasing considerably among the late-onset cohort (81%), compared to the early-onset cohort (45%).

Retirement and diminishing social networks

For many individuals, retirement heralds the onset of an ever-diminishing social network; social capital is another risk associated with late-onset problem drinking. Schonfeld et al. (1987) and Schonfeld and Dupree (1991) reported that due to late-life stressors, such as retirement and bereavement, the social support networks of the late-onset cohorts in their studies had diminished. Dupree et al. (1984) similarly reported that their subjects had poor social networks, and van den Berg et al. (2014) found there were significant differences in the context of social networks, finding that both late-onset cohorts in their study (late- and very-late-onset) spent more time on their own and had fewer friends than their early-onset counterparts. For many of Emiliussen and colleagues' (2017b) participants, retirement impacted adversely on their identity; for many people, the transition from work to retirement, means leaving behind an important social group (Steffens et al., 2016), the groups' support, and a social identity and sense of belonging that group membership fosters (Bordia et al., 2020).

Alcohol as a coping mechanism for late-life stressors — a stress-coping hypothesis

Finlayson et al. (1988) suggest that the "statistically significant association" found between late-life events and an increase in alcohol consumption and alcohol misuse, in the late-onset cohort in their study, lends support to a stress-coping hypothesis as an explanation for late-onset alcoholism (p. 766). Finlayson and colleagues (1988) hypothesise that a greater awareness of late-life events shown by many late-onset drinkers, allows them to justify their alcohol misuse. While Schutte et al.'s (1994) 4-year-long study, reported that late-life stressors and social resources were good predictors of late-onset problem drinking. Similar findings were reported in Schutte et al.'s (1998) 7-year-long investigation, which found that potential late-onset drinkers at baseline, were more likely than stable, non-problem drinkers to use avoidant coping strategies (i.e., denial) to deal with stressors.

Further support for a stress-coping hypothesis is evident in Wadd et al.'s (2011) paper. Wadd and colleagues (2011) reported that late-onset problem drinkers use alcohol as a coping mechanism to deal with a multitude of late-life events (e.g., retirement, loss of a partner, becoming a caregiver), and other stressors, such as chronic pain and financial worries. Atkinson et al. (1990) also reported that late-onset problem drinking was a reaction to late-life events/stressors. A similar theme is evident in Emiliussen et al.'s (2017c) paper. Nine of the twelve subjects in Emiliussen and colleagues (2017c) qualitative study were retired and had a non-problematic socioeconomic background (mostly white-collar workers). Their discourses revealed an overarching theme of excessive drinking as a coping mechanism to deal with boredom and inactivity, pain, insomnia, depression and low self-worth.

Bereavement and spouse/partner relationships

According to Dupree et al. (1984), the event most often reported as the catalyst for problematic drinking, was the death of a spouse. Twenty-one of the 48 subjects in their study were widowed, while a further 10 were either separated or divorced. Finlayson et al. (1988) similarly reported

that, after retirement, the stressor most associated with alcohol misuse and late-onset problem drinking was the death of a spouse or partner. In contrast, Adams and Waskel (1991a) reported that the only significant difference found in their investigation of psychosocial characteristics, was marital status: more early- than late-onset subjects were married. Adams and Waskel (1991a), however, considered the consequences of losing a spouse or partner from a different perspective. Rather than the commonly held notion that positions loss and bereavement as emotional stressors that mediate increased alcohol consumption and misuse, Adams and Waskel (1991a) suggested that because most of the late-onset cohort in their study were either divorced or widowed, their (ex/late) spouses may have acted to control and regulate the drinking of their partners (i.e., social control; see Moos, 2007).

It is important to reiterate that the three Adams and Waskel (1991a, 1991b, 1993) papers in the present review used an all-male sample; this is because their findings are contrary to the findings of other studies in the present review. Brennan and Moos (1991) for example, who reported that early-onset drinkers were less likely to be married than late-onset drinkers. However, it may be misleading to compare romantic relationships in the context of a straightforward married/not married dichotomous variable per se, and more meaningful to view romantic relationships from a much broader and more encompassing perspective. For instance, Wetterling et al (2003) found a significant difference in relationship status ($p < 0.0001$) between early- and late-onset problem drinkers, which showed that more of the late-onset cohort in their study were either married, in a relationship or widowed, compared to the early-onset cohort, suggesting that late-onset drinkers are more likely to be successful in their romantic relationships, than early-onset drinkers are.

Influential family factors

Three papers in the review considered hereditary relationships in the development of late-onset problem drinking. Atkinson et al.'s (1985) predominately male sample ($n = 36$; 33 males and

3 females) of early- (n = 14) and late-onset (n = 22) older problem drinkers found there was a much greater history of family alcoholism/AUD in the early-onset cohort (86%) compared to the late-onset cohort (41%). Nevertheless, at 41 percent, the prevalence of a family history in the late-onset cohort is still reasonably high. Atkinson and colleagues (1985) believed their paper was the first occasion that data relating to a family history of alcoholism/AUD had been used in the context of alcohol misuse among alder adults.

Atkinson et al. (1990) also found there was a stronger association of a family history of alcoholism/AUD in early-onset drinkers, than in late-onset drinkers, reporting that late-onset drinkers misuse of alcohol was primarily a reaction to late-life events/stressors and that they were less likely to have a history of psychopathology than early-onset problem drinkers. However, not only were the subjects in their investigation exclusively male (n = 146), but they were also all military veterans. Yet, this important and potentially influential variable was not a consideration and not controlled for (i.e., some of the veterans may have experienced combat and been affected by it). Wetterling et al (2003), the final study to investigate hereditary associations with late-onset drinking, reported similar findings to those presented by Atkinson et al. (1985) and Atkinson et al. (1990). Wetterling and colleagues (2003) found a significant difference regarding family history of AUD, with late-onset problem drinkers having fewer immediate family members with alcohol problems than early-onset problem drinkers. Several papers discussed family influences in different contexts (i.e., pressure and support).

Emiliussen et al. (2017a) identified four psychosocial characteristics that motivated the late-onset cohort in their investigation to seek help and enter treatment. Foremost among these factors was family pressure, which can be interpreted as a support mechanism, a social resource that is far less available to early-onset drinkers. Two other major factors were health, and the need to be self-reliant and maintain personal agency over their lives. Finally, they had an ambivalent and an open-minded attitude towards entering treatment. In a similar vein, the

primary motivating factor for seeking treatment reported by the late-onset subjects in Finlayson et al.'s (1988) study, was the concern shown by family and friends (69%). Brennan and colleagues (1991) similarly reported that late-onset drinkers had more support from their children than early-onset drinkers.

In another family-related context, Schutte et al.'s (1998) longitudinal study, which investigated the psychosocial characteristics of late-onset problem drinkers, highlighted the value of following a cohort of older adult problem drinkers over a relatively long period. Schutte and colleagues (1998) reported that baseline data suggests that certain family-related drinking behaviours and attitudes are good predictors of those individuals who go on to develop late-onset problem drinking. For example, individuals who were non-problem drinkers at baseline and who later developed late-onset problem drinking, had greater approval of their drinking from friends and family, compared to individuals who were still stable, non-problem drinkers at four- and seven-year follow-up. (*Table 2.10 on the following page lists the psychosocial characteristics that have been discussed in this section, that are present across the 26 papers.*)

Table 2.10.

Psychosocial Characteristics (including comorbid alcohol misuse/mental health)

Study		Comorbid alcohol misuse & mental health	Retirement & late-life stressors	Bereavement/spouse/ partner relationships	Influential family factors
1	Adams & Waskel (1991a)			✓	
2	Adams & Waskel (1991b)			✓	
3	Adams & Waskel (1993)			✓	
4	Atkinson et al. (1990)		✓		✓
5	Atkinson et al. (1985)				✓
6	Brennan & Moos (1991)	✓	✓	✓	✓
7	Brennan et al. (1993)	✓			
8	Christie et al. (2013)		✓		
9	Dauber et al. (2018)	✓			
10	Dupree et al. (1984)	✓		✓	
11	Emiliussen, et al. (2017a)				✓
12	Emiliussen et al. (2017b)				
13	Emiliussen et al. (2017c)		✓		
14	Emiliussen et al. (2019)				
15	Finlayson et al. (1988)	✓	✓	✓	✓
16	Fitzgerald & Mulford (1992)				
17	Kist et al. (2014)	✓			
18	Mulford & Fitzgerald (1992)				
19	Schonfeld et al. (1987)	✓	✓		
20	Schonfeld & Dupree (1991)	✓	✓		
21	Schutte et al. (1994)	✓	✓		
22	Schutte et al. (1998)	✓	✓		✓
23	Van den Berg et al. (2014)	✓	✓		
24	Van Montfoort-De Rave et al. (2017)				
25	Wadd et al. (2011)		✓		
26	Wetterling et al. (2003)	✓		✓	✓

2.4.4 Meaning and Purpose in Life

The previous sections have addressed the first question posed by the current review. This section considers the review's second, more nuanced question: *How has MPL been reported in relation to the development of late-onset problem drinking and AUD in people aged 50 and over*? According to Frankl (2014), a lack of meaning and a purpose in life can lead to existential frustration. Moreover, a lack of MPL has been associated with other negative psychological states of being, including substance/alcohol abuse (Frankl, 1972, 2014; Kleftaras & Katsogianni, 2012). Waisberg and Porter (1994) for example, found that individuals being treated for alcohol dependence had a lower sense of purpose in life than people who were not alcohol dependent. The question is framed within Frankl's (1963, 2014) theory of meaning (logotherapy), outlined in the introduction to the thesis. With the overall aim of the thesis in mind, the objective of the question is to investigate how (and if) the literature in the current review, has reported MPL in the context to late-onset AUD/problem drinking.

MPL: a scarcity of explicit reporting

Although an accumulation of evidence suggests there is an association between lack of MPL, and AUD and alcohol dependence (e.g., Chen, 2006a; Hart & Singh, 2009; Henrion, 2002; Kleftaras & Katsogianni, 2012; Straus et al., 2019; Waisberg & Porter, 1994), only two of the 26 papers in the present review reported explicitly on the construct. The first of these (Adams, & Waskel, 1991a), used the Purpose in Life Test (Crumbaugh, 1968; Crumbaugh & Maholick, 1964) to determine the extent of their subjects' MPL. Originally developed to quantify Frankl's (1963, 2014) concept of existential frustration, the scale is "a reliable and valid measure of Frankl's conception of MPL" (Crumbaugh, 1968, p. 80). The Purpose in Life test has been used extensively in the context of research and treatment for alcohol dependence/misuse (Cranford et al., 2104; Marsh et al., 2003; Song et al., 2018; Waisberg & Porter, 1994; Witkiewitz, 2021).

In contrast to the quantitative methodology employed by Adams and Waskel (1991a), the other study in the present review that reported explicitly on MPL, Emiliussen et al. (2017c), investigated the construct from a qualitative perspective. Emiliussen and colleagues (2017c) identified a relationship between a lack of meaning in life, loss of identity, and very late-onset AUD, which mostly occurred post-retirement (*m* age = 68.5). The participants' work roles were a part of their identities, giving them a sense of belonging, and making them feel they had "a role in society", giving them "a purpose in life" (Emiliussen et al., 2017c, p. 978). Emiliussen and colleagues (2017c) describe how one participant "was overwhelmed by an existential anxiety of being alone and being nobody" (p. 978). The catalyst for these feelings was the lack of meaningful and purposeful activities, needed to give meaning to their lives, following retirement.

Not only does employment enable people with the practicalities of being able to pay their bills and experience financial security but having to perform a social role every day reinforces an individual's self-worth and their social identity as a valued member of a team/group (Turner, 1991). Additionally, a social identity helps people to cope with major life transitions (Iyer et al., 2009). Perhaps, most importantly, in the context of the current review, going to work every day gives people a sense of meaning and a purpose in life, promoting feelings of self-worth, as being someone who has much to offer (Haslam, 2014). Although Adams and Waskel (1991a) and Emiliussen et al. (2017c) were the only two papers to report explicitly on MPL, four papers highlighted boredom (mentioned in the previous section) in their respective subjects/patients. As noted in the introduction to the current review, Frankl (1963, 2014) postulated that boredom and apathy are psychological manifestations of a meaningless and purposeless life.

Boredom: The psychological manifestation of a lack of MPL

There is a strong association between boredom and a lack of MPL. Indeed, statistically significant correlations (negative) have been found between the Purpose in Life test and the Boredom Proneness Scale (BPS; Farmer & Sundberg, 1986): higher Purpose in Life scores are associated with lower BPS scores (Farmer & Sundberg, 1986; Melton & Schulenberg, 2007), meaning that individuals who have greater MPL are less likely to experience boredom. Christie et al. (2013) for example, reported that 49 percent of their subjects, mostly retired or unemployed (63% and 18% respectively), drank in response to negative feelings, including boredom, with men being twice as likely as women to report they drank because of "boredom/something to do" (p. 29). Similarly, Finlayson et al. (1988), found that many of their 216 older inpatients, diagnosed with AUD, cited post-retirement boredom, using the oft repeated "more time to drink" mantra (p. 767), as being an influential factor in their excessive drinking behaviour.

The shared narrative of drinking more because of having extra time to negotiate, suggests that the cessation of daily work routines following retirement, meant that the subjects/ patients in both Christie et al.'s (2013) and Finlayson et al.'s (1988) investigations, lacked structure in their lives, something that Van Montfoort-De Rave et al. (2017) highlighted. Van Montfoort-De Rave and colleagues (2017) recommended bespoke treatment programmes for older, late-onset problem drinkers, which included interventions specific to this population, with "meaningful daily activities" being foremost among them (p. 144). Van Montfoort-De Rave et al.'s (2017) recommendations are predicated on the notion, that a "loss of daily structure and/or social network", that follow retirement, can lead to boredom and an increase in substance use (p.144). Wadd et al.'s (2011) report, *Working with Older Drinkers*, is the final paper to report an association between retirement, boredom and increased alcohol consumption. This section concludes, appropriately, with a quote by an older, late-onset

drinker, taken from the report, succinctly expressing their feelings of boredom "what am I going to do with this time, how am I going to fill my days" (p. 8).

2.5 DISCUSSION

Why do some older adults with no history of problematic drinking begin to consume alcohol excessively and harmfully? The present thesis presents one explanation for this phenomenon. The thesis, framed within Viktor Frankl's (1963, 2014) theory of meaning (logotherapy), advances the notion that many individuals who develop late-onset AUD/problematic drinking later in life, do so, in part, because of a lack of MPL. The thesis further proposes that major biological, psychological and social events that occur later in life, are often the catalyst for this meaningless and purposeless state of being (i.e., *existential vacuum*). That major, late-life events are associated with late-onset drinking is not a novel idea. Rosin and Glatt (1971) were among "the first to identify two distinct groups of elderly alcoholics" (Ticehurst, 1990, p. 256). Rosin and Glatt (1971) had observed in the *reactive* (late-onset) group, that "previous innocuous drinking was exacerbated by the physical, mental and environmental effects of aging" (p. 55). However, the author is confident this is the first time that late-onset problem drinking has been investigated from a Franklian perspective. The current literature review was the starting point of the investigation. This section discusses the review's findings, and considers directions for future research, policy, and treatment. It became evident very early in the review process (during the literature search), there was a disparity across the literature, in how the cut-off age for late-onset AUD/problematic drinking has been defined. Standardising a cut-off age was, therefore, the starting point of the current review.

Towards a standardised cut-off age for late onset AUD/problem drinking.

The impact that the COVID-19 pandemic has had on late-onset drinking cannot be underestimated. After the first lockdown in 2020, for example, there were an estimated 171,000

people aged 55 and over in the UK, with "probable alcohol dependence" (Rao et al., 2021, p. 1). Additionally, PHE (2020) found that since the pandemic in England, the highest prevalence for consuming above the recommended 14 units of alcohol a week, was among adults aged 55 to 64. Therefore, it is vitally important that health and social care professionals, who encounter older adults regularly, are aware of the phenomenon of late-onset AUD/problem drinking. In this context, having a standardised cut-off age for when late-onset drinking is likely to emerge would be extremely beneficial. However, the disparity in late-onset cut-off ages presented in the current review, shows this has yet to be achieved. It is also not helpful, that a standardised age range for predicting when 'late-life events' are likely to occur has yet to be defined; evident in studies of late-life events in various contexts such as, bereavement and depression (Bruce, 2002; Rosenzweig et al., 1997), stressors and problematic drinking (Brennan & Moos, 1990; Moos et al., 2005) and stressful late-life events in general (Holahan et al., 2005; Moos et al., 2006), where a broad age range of between 50 and 65 years of age is commonly used.

A combination of the variance in cut-off points presented in the current reviews' papers (m = 52.69), and the participants' self-reported age of onset (m = 56.79), suggests an approximate age range when late-onset AUD/problematic drinking is likely to emerge, is 55-years of age (and after). However, this approximation is based on the reviewed papers, and other important variables should be considered. For example, self-reports of when their first drinking problem occurred was reported by late-onset respondents in only ten of the reviewed papers. Additionally, family members and friends often report that problem drinking begins at an earlier age than that reported by the problem drinkers themselves (Finlayson et al., 1988; Schonfeld and Dupree, 1991), Moreover, it has been sufficiently documented that self-report surveys tend to deliver underestimations of alcohol consumption (Stockwell et al., 2008; 2014).

Taking the above variables into account, an earlier age of 50-years of age is suggested, cautiously, as an approximate age when late-onset problematic drinking is likely to emerge.

That said, any firm recommendations regarding a standardised cut-off age, will be determined by the research undertaken in the main body of this thesis. Again, the purpose of moving towards a universal cut-off age, is about establishing an approximate temporal range, when late-onset AUD/problem drinking is likely to emerge. A universal definition for the age of late-onset is useful in two contexts. Firstly, in the context of research, the present review has shown that a standard cut-off age is long overdue. Secondly, and more importantly, a universal cut-off age can better inform health and social care professionals about the needs of this unique group of older problem drinkers.

Recognising gender differences.

The most common gender difference found was that there are a significantly higher proportion of women (vs. men) among late-onset drinkers, compared to the proportion of women (vs. men) among early-onset drinkers. Similar findings on older women drinkers in general (e.g., Blow, 2000; Cowart & Sutherland, 1995; Epstein et al., 2007; Green, 2006) support this finding, suggesting that the risk of women developing problematic drinking increases considerably with advancing age. Furthermore, late-onset women tend to be older than late-onset men (Christie et al., 2013; Dauber et al., 2018). However, the current review found that typically, gender differences are not always considered by health and social care professionals when screening for late-onset AUD/problematic drinking. Interestingly, the review found that although women were less likely to seek treatment then men (due to stigma, shame and denial), when they did, they were more likely to engage and were more treatment compliant than men (e.g., Emiliussen et al., 2017a, 2017a; Grosso et al., 2013; Share et al., 2004). The current review presents a good case for alcohol practitioners and other healthcare professionals working in the field of alcohol/substance abuse, to develop treatment pathways designed specifically for women. Indeed, several of the studies in the current review have highlighted the need for gender-specific interventions/treatment. From a social perspective, for example, Dauber et al. (2018)

recommended that, "an integration of social aspects into treatment for older women may be useful" (p. 8), while Brennan et al. (1993) suggest that screening and treatment programmes "should be tailored more closely to the life circumstances of women with late-life drinking problems" (p. 781).

A call for a greater awareness of late-onset psychosocial characteristics.

The presence of comorbid alcohol dependence and mental health disorders in late-onset drinkers appeared more often than any other psychological characteristic in the current review. The strong association between heavy alcohol use/dependence and poor mental health is well documented (e.g., Gerrits at al., 2015; RCPSYCH, 2018). The temporal order of the association is unclear; in all probability, alcohol misuse and poor mental health are mutually causative (Liang & Chikritzhs, 2011). For example, on one hand, poor mental health encourages maintenance of heavy drinking (Bell & Britton, 2014), while on the other, the "Harmful use of alcohol" is "a key risk factor for noncommunicable diseases and mental health conditions" (WHO, 2019a, p. 2). After mental health disorders, retirement was the most prevalent psychosocial risk factor reported. Most older adults manage to maintain psychological stability and overall well-being following retirement, but there are some who are unable to cope with the new challenges they face (Henning et al., 2016). They may, simply, not be equipped with the resilience that is necessary in the transition to retirement (Murakami, 2021; Nalin & França, 2015); late-onset problem drinkers fall into this category. Other prevalent psychosocial risk factors included bereavement, pain, social isolation and exclusion, loneliness and boredom, risk factors that tend to compound each other, i.e., bereavement can lead to loneliness and isolation, which in turn can lead to changes in drinking behaviour (Nicholson et al., 2017; Shaw & Palattiyil, 2008). Of course, these risk factors culminate in many older late-onset problem drinkers regularly presenting at a variety of health and social care settings (e.g., primary care, social care, hospital settings and mental health services).

However, all too often, older, late-onset problem drinking is not identified. In part, this is often because of the individual's reluctance (due to stigma, shame and denial) to talk about their drinking. However, it can also be a failing on the part of the professional practitioner who fails to recognise symptoms. Such oversights among health and social care professionals are due, in part, to poor training and fixed attitudes and assumptions towards older adults (Dar, 2006), or simply because they are unaware of alcohol problems in older people (RCPSYCH, 2018). Synthesizing the main psychosocial characteristics reported in the 26 papers in the current review, an accurate picture of the prevalence of each characteristic can be expressed and thus, lend further support to existing knowledge. Table 2.10 (see p. 60) shows the distribution of the main psychosocial characteristics across the papers in the review, highlighting the prevalence of each of the main characteristics.

The role of MPL in recovery — a dearth in reporting

Reported by only two papers (Adams & Waskel, 1991a; Emiliussen et al., 2017c), it is clear the role of MPL in late-onset drinking, has received scant attention in the literature. Moreover, it is evident that researchers have not considered investigating late-onset drinking theoretically, from a Franklian perspective. Indeed, not a single reference to Frankl appears in any of the papers in the current review. Yet, it is widely accepted that re-discovering MPL is associated with sustained recovery. This is certainly the case in AA and other 12-step programmes (Carrol, 1993; Galanter, 2007; Gomes & Hart, 2009; McInerney et al., 2021; Oakes, 2008), and recovery in general (Krentzman et al., 2015; Roos et al., 2015; United Nations Office on Drugs and Crime [UNODC], 2008; Waisberg & Porter, 1994; White et al., 2006; WHO, 2020).

After mental health disorders, the current review reported retirement as the most prevalent psychosocial risk factor for late-onset drinking. It may prove useful to consider retirement in the context of MPL. For many late-onset drinkers, retirement means the withdrawal of meaningful and purposeful daily activities (e.g., Christie et al., 2013; Finlayson

et al., 1988), which in turn, as postulated by Frankl (1963, 2014) generates existential frustration, which manifests as boredom, i.e., "what am I going to do with this time" (Wadd et al., 2011, p. 8). Retirement for many late-onset drinkers then, is an existential crisis. To address such a crisis, tailored treatment programmes for late-onset drinkers, have been recommended, that should include "meaningful daily activities" (Van Montfoort-De Rave et al., 2017p. 144), to fill the void, once occupied by the meaningful and purposeful activities of daily work. In doing so, Van Montfoort-De Rave and colleagues (2017) advocate, not only Frankl's (1963, 2014) solution to existential frustration, but also an indispensable and natural component of RC, "(Re) discovering meaning and purpose in life" (UNODC, 2008, p. 17).

2.5.1 Treatment and recovery pathways for late-onset drinkers: a synopsis

Three themes relating to treatment for, and recovery from late-onset problem drinking emerged during the current review (Table 2.11). Firstly, it is widely agreed that tailored, age-specific treatment programmes, can be beneficial for this unique population: "matching of treatments to specific subgroups of alcohol abusers is an appropriate means of achieving higher recovery rates" (Fitzgerald and Mulford, 1992, p. 1291). Next, the recognition that late-onset drinkers, particularly women, are more treatment compliant and are more likely to maintain abstinence than early onset drinkers, lends support to the first theme and the call for bespoke recovery pathways for older, late-onset drinkers. The third and final theme suggests that having access to greater RC (e.g., family and social support, physical and mental health, etc.) can lead to improved outcomes for older, late-onset problem drinkers, compared to older, early-onset problem drinkers.

Table 2.11

Recovery/treatment-related themes

Study		**Theme 1** Bespoke, age-specific treatment programmes are beneficial for LO problem drinkers.	**Theme 2** LO problem drinkers are more treatment compliant than EO problem drinkers.	**Theme 3** Greater access to RC leads to improved outcomes for LO drinkers.
1	Adams & Waskel (1991a)	—	—	—
2	Adams & Waskel (1991b)	—	—	—
3	Adams & Waskel (1993)	—	—	—
4	Atkinson et al. (1990)	✓	✓	✓
5	Atkinson et al. (1985)	✓	✓	✓
6	Brennan & Moos (1991)	✓	✓	✓
7	Brennan et al. (1993) *	—	—	—
8	Christie et al. (2013)	—	—	—
9	Dauber et al. (2018)	✓	✓	—
10	Dupree et al. (1984) **	✓	—	✓
11	Emiliussen, et al. (2017a) ‡	✓	—	✓
12	Emiliussen et al. (2017b)	✓	—	✓
13	Emiliussen et al. (2017c)	✓	—	✓
14	Emiliussen et al. (2019)	—	—	✓
15	Finlayson et al. (1988)	✓	—	—
16	Fitzgerald & Mulford (1992)	✓	✓	—
17	Kist et al. (2014)	✓	—	—
18	Mulford & Fitzgerald (1992)	—	—	—
19	Schonfeld et al. (1987)	✓	—	✓
20	Schonfeld & Dupree (1991)	✓	—	✓
21	Schutte et al. (1994)	—	✓	✓
22	Schutte et al. (1998)	✓	✓	✓
23	van den Berg et al. (2014)	—	—	—
24	Van Montfoort-De Rave et al. (2017)	✓	—	✓
25	Wadd et al. (2011)	✓	✓	✓
26	Wetterling et al. (2003)	✓	✓	—

*Brennan et al. (1993) investigated gender differences; therefore, combined gender treatment themes were not reported.

**Dupree et al. (1984). The Gerontology Alcohol Project (GAP) was developed specifically for older problem drinkers.

‡ Emiliussen et al. (2017 a, 2017b, 2017c). There were no early-onset comparison groups in these studies.

2.5.2 Key findings

Key Findings of the review

- The mean age of the reviews' 26 papers suggests that late-onset AUD/problem drinking is likely to emerge at around 50-years of age.
- There is a high prevalence of comorbid mental health disorders among late-onset drinkers.
- Retirement was reported as the most prevalent psychosocial risk factor associated with late-onset drinking.
- Other prevalent late-life risk factors included: bereavement, loneliness, isolation and boredom.
- The risk of women developing late-onset problem drinking increases with age.
- Late-onset problem drinkers, particularly women, tend to be more treatment compliant than early-onset problem drinkers.
- There is a case for bespoke treatments/interventions for late-onset women drinkers.

2.5.3 Limitations of the review

The limitations of the current review need to be recognised. Firstly, it should be noted that because the review was authored by a single researcher, there was a greater risk of data selection biases. However, the author used the CASP (2021) checklist to mitigate against biases. Without the benefit of co-researchers to corroborate the quality and validity of study selection and data extraction, the CASP (2021) checklist is a useful tool that encourages the researcher to take methodological biases into account (see *Appendix 2.5*, for example). It is also important to recognise that the review was limited to English language journals. Indeed, not only were all the papers in English, but all the data were harvested, and culturally situated, in the 'West' (i.e., Europe, USA). In common with all reviews, there is always the likelihood that the search terms and strategies used did not return all relevant papers, which is evident in the current review, several papers in the review were returned using an iterative method of searching the references of papers. Finally, many of the selected papers only investigated

populations with diagnostic labels (i.e., AUD), whereas the terminology in the current review, i.e., 'AUD/problematic drinking' aimed to be more representative of the late-onset population.

2.5.4 The way forward

In common with previous investigations, the current thesis will investigate the associated psychosocial characteristics of the overlooked population of older, late-onset problem drinkers, of whom, less than 15% seek treatment (Age UK, cited in Commission on Alcohol Harm, 2021). The review found that MPL, or more correctly, lack of MPL, has not been fully considered in the context of late-onset drinking in older people. The current thesis hypothesises that this important psychological and motivational construct, plays a key role in the developmental process of late-onset drinking in older people, and will test this hypothesis accordingly. Moreover, and of equal importance, the thesis explores if (re) discovering MPL has a role to play in recovery from late-onset problem drinking.

Regarding recovery, the current review found that late-onset drinkers, particularly women, are affected by the stigma associated with alcohol (e.g., Van Montfoort-De Rave et al., 2017; Wadd et al., 2011). Yet, many of the reviewed papers use a plethora of clinical labels that stigmatise, such as, *late-onset alcohol dependence* (e.g., van den Berg et al., 2014), *late-onset alcoholics* (e.g., Adams & Waskel, 1991a), and *late-onset alcohol abusers* (Schonfeld et al., 1987). Widely recognised as unhelpful (Kelly et al., 2010; Kelly at al., 2016; Wakeman, 2019), stigmatising language and labelling act as barriers to seeking treatment (Emiliussen et al., 2017b), and additionally, have the potential to influence the perceptions of healthcare professionals and their decision making (Ashford et al., 2019). Moreover, many late-onset drinkers do not meet the criteria for either a DCM-V (APA, 2013) diagnosis for AUD, or an ICD-11 (WHO, 2019b) diagnosis of alcohol dependence. Therefore, moving forward, the current thesis uses terminology that is relevant to the population being studied: *late-onset AUD/problem drinking*, or simply, *late-onset problem drinking*.

The following chapter outlines the methodology used in the main body of the thesis to achieve its aims and objectives.

Chapter endnotes

1. Library Plus is a database that searches other databases, including: The Allied and Complimentary Medicine Database (AMED); CINAHL Complete; MEDLINE; PsychArticle; PsychINFO; Psychology and Behavioural Sciences Collection.
2. The CASP (2021) cohort study appraisal tool is a 12-question checklist designed to assist researchers in their appraisal of studies. The questions are arranged into three broad categories: a) The study's validity, b) The results, c) The useful application of the results to the population of concern. The checklists enabled the 26 studies included in the review to be appraised systematically and confirm their suitability for inclusion, and the more resource intensive task of data extraction.
3. In the context of when the current review was undertaken (i.e., 2021), the relationship between social isolation and problematic alcohol consumption, as experienced by many older people, was exacerbated by the COVID-19 pandemic (i.e., Garnett et al., 2021; Seddon et al., 2021).
4. When the DSM-III was published, the term **alcoholism** was dropped and replaced with two distinct disorders, **alcohol abuse** and **alcohol dependence**. These categories remained in place until the publication of the DSM-V, after which time the two categories were united to form a single disorder: **alcohol use disorder** (**AUD**), with three sub-classifications, **mild, moderate** and **severe** (classification being based on how many of the 11 diagnostic criteria are met). Much of the alcohol-related language and terminology in usage before the publication of the DSM-V in 2013, is present in several of the earlier studies in the current review, which were published between 1984 and 2011, and as such, language and terminology that is no longer in common usage, has occasionally been cited, most specifically where verbatim quotations have been used (i.e., **alcoholics, alcohol abusers, abusive alcohol pattern, alcohol dependence, alcohol dependent**).
5. Atkinson, 1990, nor Schuckit et al.,1976 are not included in the current review, as they reported on gerontology and AUD in a general way (i.e., diagnoses of AUDs in all older problem drinkers, older male alcoholics in clinical settings), not specifically late-onset drinking.
6. For a list of the psychometric instruments used, refer to the corresponding study in Table 2.4. Additionally, for a comprehensive list of all the instruments used in the papers in the current review and bibliography, refer to *Appendix 2.4. Instruments used in the reviewed papers*.

CHAPTER THREE

METHODOLOGY AND THEORETICAL FRAMEWORK

3.1 INTRODUCTION

The systematic literature review in the previous chapter found that although many psychosocial characteristics associated with late-onset AUD/problem drinkers have been reported, there is an overall dearth of research regarding this cohort of problematic drinkers, particularly in the context of recovery. Thus, there exists a gap in knowledge in relation to this unique group, that comprises one-third of all older adults who experience problems with alcohol (Van Montfoort-De Rave et al., 2017; Wadd et al., 2011). Moreover, the review highlighted that the psychological construct of MPL, in the context of late-onset AUD/problem drinking, has also received scant attention in the literature; it is important to highlight this specific construct at this stage, because of its association to the thesis' theoretical framework: Viktor Frankl's (1963) theory of meaning, logotherapy.

Psychiatrist and psychotherapist, Viktor Frankl's theory of meaning, or logotherapy, was born from, and developed out of his own traumatic lived experience and suffering in the Nazi concentration camps in World War II (Frankl, 1963). After arriving at Auschwitz, Frankl was stripped of his clothes, which included, secreted in one of the pockets, the manuscript of his unfinished first book. He likened the experience of having his cherished manuscript taken from him, as having to come to terms with the loss of his "mental child" (Frankl, p. 118). In place of his own clothes, he was given the rags of an unfortunate, fellow inmate who had been systematically dispatched to the gas chamber. Inside a pocket of his newly acquired attire, Frankl found a page, torn from a Hebrew prayer book, containing an important Jewish prayer, the *Shema Yisrael*

The overarching objectives of the current thesis then, are to undertake a thorough investigation of MPL, along with a further, comprehensive investigation of the other psychosocial characteristics, and importantly, the recovery pathways associated with this population, and thereby contribute to a greater understanding of the phenomenon of late-onset AUD/problem drinking. This chapter presents the methods used to achieve those objectives, and effectively bridge some of the gaps in the current knowledge of the topic under investigation. The chapter first describes the theoretical framework that the current research is situated within, before outlining the main aims of the research; the overall design is then described. Other important theoretical and methodological considerations are discussed.

3.2 THEORY

"He who has a WHY to live for can bear with almost any HOW"

Nietzsche (cited in Frankl, 1963. P. 83)

Origins of Frankl's logotherapy

His experience in Auschwitz had a profound spiritual effect on Frankl, encouraging him to adopt an attitude of living out the thoughts expressed in his unfinished manuscript, rather than solely committing them to paper. This newly developed phenomenological attitude, a new way of being (see 3.6, IPA), coupled with an unwavering resilience, helped him to survive the inhumanity of his internment and the horrors of the Holocaust: "Our generation is realistic, for we have come to know man as he really is. After all, man is that being who invented the gas chambers of Auschwitz; however, he is also that being who entered those gas chambers upright, with the Lord's Prayer or the *Shema Yisrael* on his lips" (Frankl, 1963, p. 136).

Frankl's lived experience of finding meaning in the darkest, most terrifying and distressing situation imaginable, led him to believe and eventually propose, that the primary force that motivates all human beings, is an innate need to find MPL, "*the will to meaning*" (Frankl, 2014, p. 9). He further proposed that when this innate human need is not fulfilled, the

individual is prone to experience existential frustration, a feeling of emptiness. The focus of logotherapy is on the meaning of human existence, viewing people "as meaning-seeking and meaning-making" beings (Wong, 2013, p. 619). A Greek word, mostly associated with Aristotle, *logos* has many meanings (see Moss, 2014). some scholars, for example, argue that the word's primary meaning is *reason* (e.g., Crisp, 2014; Pakaluk, 2005). Frankl, however, viewed the word as a metaphysical concept that referred to the primary cosmic force, which Frankl interpreted as *meaning*, hence logotherapy. Frankl's interpretation is in accord with the original understanding of logos, advanced by Heraclitus (c. 6th century BC). According to the metaphysics of Heraclitus, *logos* is the principle that "the world is ordered, guided, and unified by a rational structure, a single divine law" (Viktor Frankl's Logotherapy, 2011).

Frankl's theory of meaning applied to the current research

In accordance with Frankl's theory, the current research advances the notion that many people who experience late-onset AUD/problem drinking, may be experiencing a particular form of existential frustration in their lives, referred to as an 'existential vacuum', which manifests as boredom and apathy (Frankl, 2014 p. 61). In other words, their lives are without meaning, a state of being that is born from major events that tend to be experienced later in life (i.e., bereavement of a partner, retirement, social isolation, etc.). It is important to emphasise, in the context of the current research's theoretical framework, that meaning-centred therapies have been used in treatment programmes for alcohol dependence (Crumbaugh, 1981; Henrion, 2002; Waisberg & Porter, 1994), and problematic drinking in general (Wong, 2013; Thompson, 2018). Additionally, MPL is known to mediate recovery (Krentzman et al., 2015; Lyons et al., 2010; Oaks, 2008). The present research proposes that a proportion of the cohort under investigation use alcohol to fill their existential vacuum; a construct that may also be characterised as a spiritual malaise. Logotherapy is concerned with helping the individual to overcome their spiritual inertness by developing and nurturing spiritual meaning in their lives.

Philosophically, logotherapy assumes an existential-phenomenological perspective, and the term spiritual here, is contextualised as *what it means to be human*.

Ontological position

Ontologically, logotherapy assumes a relativist position; that is, meaning is not universal, it is personal, and because meaning is personal, every individual is responsible for finding their own MPL; meaning is something that cannot be given. Moreover, Frankl himself, posited the notion of a "dimensional ontology" (Frankl, 2005, p. xiii); "Man lives in three dimensions: the somatic, the mental and the spiritual", emphasising the spiritual dimension because, "it is what makes us human" (Frankl, 1969, p. 9).

Epistemology

It is difficult to assign a formal epistemological framework to logotherapy. Frankl avoided developing a precise philosophy to accompany logotherapy per se, indeed, "he repeatedly described what logotherapy *is* not" (Bruner, 2012, p. 45). His primary interest in logotherapy was in its clinical application, which he felt would be compromised by the boundaries and laws that inform a more formalised epistemology (Neubauer, 2019). However, according to Bruner (2012, p. 45), there is enough "implicit evidence", in Frankl's thoughts and discourses on a range of topics, including phenomenology, to support an elementary, Franklian epistemology. For instance, his statement that, "phenomenology is an attempt to describe the way in which man understands himself, in which he interprets his own existence" (Frankl, 2014, p. xvi), can be viewed from an epistemological perspective; that is, the nature of knowledge is interpreted by the individual, and similarly to Frankl's ontological position, is relative. Further clarification of phenomenology as the source of a less formal Franklian epistemology can be seen, in hermeneutic (interpretative) phenomenology (HIP). HIP's epistemological assumptions can be summed up thus, a) the "observer is part of the world", b) "not bias free", and importantly, c) "understands phenomenon by interpretative means" (Neubauer, 2019, p. 92). This is not meant

to be an exhaustive investigation of the exact philosophical inferences about logotherapy, rather it is aimed at presenting a broad and practical set of rudimentary epistemological assumptions and how they can inform a research design.

Healthcare model perspective

Because of the multiple physiological and psychological health issues associated with problematic alcohol use, it is useful to consider logotherapy from a healthcare perspective. When he posited the notion that "therapy should be extended to take in the spiritual sphere" (Frankl, 1969, p. 245), Frankl placed spirituality as a central feature of his theory of meaning. This means that within a Franklian context, it is not wholly appropriate to consider healthcare framed within the standard, biopsychosocial model of healthcare, which by default, assumes a dualistic position, separating mind and body. However, Sulmasy (2002) has complemented Engel's (1977) model by adding a spiritual domain: 'genuinely holistic healthcare must address the totality of the patient's relational existence' (Sulmasy cited in Saad et al., 2017, p. 2).

Moreover, a growing body of research acknowledges the benefits of spiritual care, in the context of health and well-being (e.g., Britt & Acton 2022; Puchalski et al., 2014; Puchalski et al., 2009), be it from a religious perspective or an existential one (Moadel et al., 1999). Additionally, from the perspective of Frankl's theory of meaning and within a healthcare context, a conference on spiritual care has defined spirituality as "the aspect of humanity that refers to the way individuals seek and express MPL and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski, et al., 2009, p. 887). However, it should be emphasised that the three dimensions contained within Engel's original model (i.e., biological, psychological and social), are of equal importance when addressing alcohol-related harm in people with late-onset AUD/problem drinking.

3.3 METHODOLOGICAL FRAMEWORK

Choosing the appropriate methodology

To understand the unique characteristics attributable to a specific sub-population within a larger population, in this instance late-onset problem drinkers within the general population of problem drinkers, it needs to be ascertained what separates them from the general problematic drinking population, i.e., early-onset problem drinkers. In short, their similarities and differences need to be identified and compared. Comparative research methods have been used across all social sciences to analyse and explain the similarities and differences between the populations or phenomenon being investigated. "Comparison as a scientific method refers here to the research approach in which two or more cases are explicitly contrasted to each other, with regards to a specific phenomenon or along a certain dimension, in order to explore parallels and differences among the cases" (Azarian, 2011, p. 3). Thus, in common with many of the papers reported in the literature review, the research undertaken in this thesis adopts a *comparative methodology*.

The primary objective of the current research then, is to establish a better understanding of late-onset problem drinkers and determine what distinguishes them from the general population of problematic drinkers. To achieve the primary research objective, the current research investigates the two distinct cohorts of early- and late-onset problem drinkers across three domains, psychosocial characteristics, the psychological construct of MPL, and recovery pathways. Comparing the similarities and differences between the two groups across these three domains is the most effective way of informing the aims of the current research.

3.4 RESEARCH AIMS/QUESTIONS

The aims of the research contained within this thesis are to answer the following questions:

1. Investigate and compare the psychosocial characteristics of late-onset problem drinkers in recovery and the psychosocial characteristics of early-onset problem drinkers in recovery when both cohorts were drinking.
2. Investigate the psychosocial characteristics of late-onset problem drinkers in recovery and compare them with the psychosocial characteristics of early-onset problem drinkers in recovery.
3. Explore and compare the role of MPL, between early- and late-onset problem drinkers, who are in recovery.
4. Investigate and compare the recovery pathways of early- and late-onset problem drinkers, who are in recovery.

Chapter four addresses the first research question. Chapters five and six both address the remaining three research questions. That said, chapter five considers the role of MPL from a qualitative perspective, whereas chapter six considers the role of MPL from a quantitative one.

Hypotheses

1. It was hypothesised that there would be recognisable psychosocial characteristics differences between late-onset problem drinkers and early-onset problem drinkers, when both cohorts were drinking. (determined by Chapter four)
2. It was hypothesised that MPL would be a more prominent feature in the discourses of early- and late-onset drinkers in recovery, compared to when both cohorts were drinking. (determined by Chapter five)
3. It was hypothesised that, regardless of onset-type, there is an association between the degree of MPL in individuals in recovery and their length of time in recovery. (determined by Chapter six)

3.5 METHODS

Defined '*as research in which the investigator collects and analyses data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study or a program of inquiry*' (Tashakkori & Creswell, 2007, p. 4), the current thesis used a mixed-methods (MM) design. Typically, the method that a researcher chooses is dependent on the method's usefulness in being able to answer the question/s the researcher seeks to address. Some questions, however, cannot be answered wholly by using a single method. How for instance, can such nuanced constructs, such as spirituality and human meaning, and discussed in this thesis, be fully and satisfactorily investigated using quantitative measures alone? Of course, the answer is that they can, but only in a limited way; the current research, for example, uses quantitative measures to quantify the presence of MPL, in people. In the context of the current research questions, however, it is questionable if quantitative methods alone are capable of fully capturing the nuanced discourses of human lived experience. Can quantitative methods, for example, interpret and present meaning and spirituality, from the perspective of the individual and the individual's own interpretations of meaning and spirituality?

According to Doyle et al., (2009, p. 175), MMs allow researchers to challenge the "false dichotomy" between qualitative and quantitative methods. To explain the relationship between the two methods in the current research, it is useful to look to the procedural MM models for collecting data, such as those developed by Steckler et al. (1992), which are graphically presented below (Figure 3.1). In model one, qualitative methods are used in the development of a primarily quantitative study. In model two quantitative method are employed to add value to research that is primarily qualitative. Model three shows qualitative methods in a supporting role, helping to explain the findings of quantitative research. It is the fourth and final model, however, that best describes the relationship between the qualitative and quantitative methods

in the current research, where each method contributes equally and in tandem to data collection and, ultimately and importantly answer the research questions.

Indeed, the first guideline in a set of MM sampling guidelines compiled by Teddlie and Yu (2007, p. 96), suggests that "The sampling strategy should stem logically from the research questions and hypotheses that are being addressed by the study". Particularly relevant in the context of the current research and an important consideration in MM sampling procedures is "The strand of a research design" (Teddlie, & Yu, 2007, p. 85). The 'strand' being a construct comprised of three stages: conceptualisation, experiential (methodological/analytical) and inferential (Tashakkori and Teddlie, cited in Teddlie, & Yu, 2007). Strands are either qualitative or quantitative and typically both are present throughout all three stages, as in the current research.

The qualitative strand runs throughout the research questions. Firstly, it is most obviously present in the qualitative interview phase of the research. Concerned with eliciting data regarding the psychosocial characteristics of the sample population and recovery pathways, the qualitative strand primarily addresses the first two research questions and the fifth and final question. However, the interview schedule has been developed and structured to draw out rich, meaningful data about the psychological construct, MPL. As such, the qualitative strand is present, and makes a considerable contribution to answering the two questions that are addressed, primarily, using a quantitative method (questionnaires). Similarly, the quantitative component is a constant strand present throughout the research questions. As well as undertaking its primary aim of investigating MPL, the quantitative method, in the form of the questionnaire, supports the qualitative research questions that investigate psychosocial characteristics and recovery pathways, which are primarily investigated during the qualitative, interview phase of the thesis.

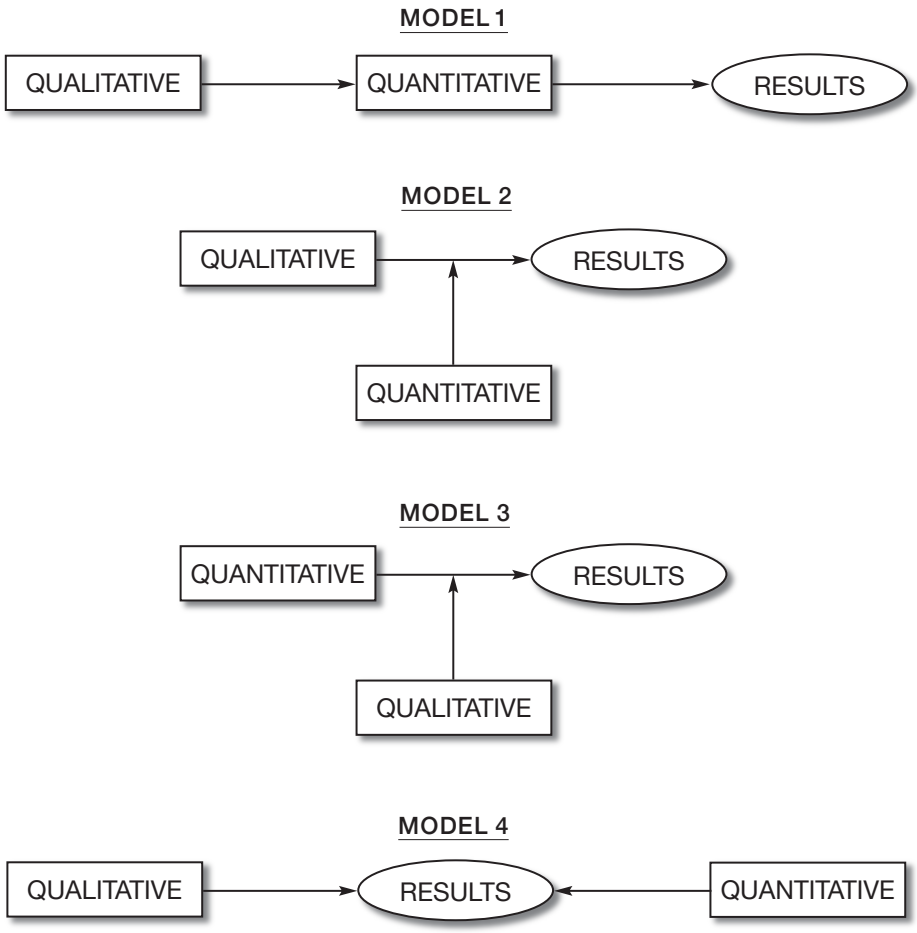


Figure 3.1.

Varying mixed-method process for data collection (Steckler et al., 1992).

3.6 QUANTITATIVE METHOD.

Surveys and questionnaires are one of the most common methods of data collection in the health and social sciences, typically comprised of "highly standardised response options so that data can be easily analysed and compared" (Schofield, & Forrester-Knauss, 2010, p. 214). In common with all research methods, and given that it has proven validity and reliability, the primary function of any questionnaire is its effectiveness in answering the research questions posed by the study. Additionally, it is important that quantitative measures have the discriminant validity to be able to statistically determine the characteristics of group membership (i.e., early- and late-onset problem drinkers). In the context of the current research, for example, are the questionnaires used capable of quantifying the psychological construct of MPL? The quantitative component in the current research, consists of a stand-alone cross-

sectional study designed to compare the early- and late-onset cohorts, regarding MPL, as well as their demographic characteristics. In contrast to a longitudinal cohort study, which follows and measures the changes of the sample population across a timespan, a cross-sectional design measures a population at a fixed, single point in time. The accompanying qualitative component of this research can be viewed as complementary to the quantitative component, in that its interpretative method views the object of investigation, across a broader time spectrum.

Additionally, in the context of the current research, there are useful benefits to using questionnaires. Firstly, they harvest data about phenomena that cannot be directly observed or measured (Bowling 2002, cited in Schofield, & Forrester-Knauss, 2010), MPL, for example. Moreover, if questionnaires are delivered online (as is the case in the current research), they can capture a wider geographical sample, potentially global (Sarantakos, 2005, cited in Schofield, & Forrester-Knauss, 2010). Two measures were used for this purpose, The Purpose in Life test (Crumbaugh & Maholick, 1964), and the Meaning in Life Questionnaire (MLQ; Steger et al., 2006), along with a demographic form.

It is important, however, to recognise the limitations of questionnaires, particularly biases, which are a common problem in their development. A literature review undertaken by Choi and Pak (2005), for example, identified as many 48 different biases in questionnaires. In the context of an epidemiological definition, biases here, refers to the "systematic deviation of results or inferences from truth" or the "processes leading to such deviation" (Porta, as cited in Brault, & Saxena, 2021, p. 514). To control for biases, questionnaire scales are scrutinised for the psychometric properties of reliability and validity during their development, as is the case with the questionnaires used here. A GPower, sample size calculation for a *t*-test between-group design, indicated that a sample size of (at least) 128 people (64 in each group), would be sufficient to elicit a medium effect size (refer to *Appendix 3.1*). The questionnaires, including the demographic form are discussed below.

3.6.1 Considering appropriate psychometric measures

Several scales were considered before deciding which scales were the most psychometrically appropriate to measure MPL in the context of the sample population being investigated in the current thesis (i.e., late-onset problematic drinkers). According to Steger et al. (2006), most of the research into human meaning has been reported by one of the following three measures: the Life Regard Index (LRI; Battista, & Almond, 1973), the Purpose in Life test (Crumbaugh, & Maholick, 1964) discussed above, and the Sense of Coherence-Meaning Scale (SOC-M; Antonovsky, 1993). Using confirmatory factor analyses (CFAs), Steger's (2007) investigation, questioned the structural validity of Battista and Almond's (1973) scale. The SOC-M (Antonovsky, 1993) on the other hand is reliable and valid. Antonovsky's (1993) theoretical position is parallel with a Franklian perspective concerning meaning, i.e., Antonovsky posited the notion that people's health can be influenced in a positive way, if they "view their life", "and their essence of existence", in terms of find meaning in life (Eriksson, & Lindström, 2005, p. 461). However, SOC-M tends to increase with age, and therefore, is not an ideal measure to use on the current population, all of whom are older adults, and whose data would likely generate similar SOC-M ratings.

One further measure was considered, the Existence Scale (ES; Längle et al., 2003). Based on Frankl's (1963) theory of meaning, the ES is a 46-item questionnaire, divided into four sub-scales, to measure existential fulfilment across four domains: *realistic perception*, *free emotionality*, *decision-making ability* and *responsibility*. External validity was established by applying two self-rating scales and three other measures: the Depression-scale (Zerssen, 1976), the Eysenck Personality Inventory (EPI; Eysenck, & Eysenck, 1965) and the Purpose in Life test (Crumbaugh & Maholick, 1964). Internal consistency across the four sub-scales, was found to be "satisfactory" (Längle et al., 2003, p. 140). However, the ES, as far as is known, has not

been used to measure existential frustration (lack of MPL) in the context of AUD/problematic drinking, and therefore, was felt to be inappropriate to use in the current research.

Although, at the time of its development, Steger et al.'s (2006) MLQ, was used to a lesser degree than the LRI (Battista, & Almond, 1973), the Purpose in Life test (Crumbaugh, & Maholick, 1964) and the SOC-M (Antonovsky, 1987), it has since been used comprehensively in the context of research on alcohol abuse in older problematic drinkers (e.g., Bupić, & Bogović Dijaković, 2019) and alcohol and substance abuse generally (e.g., Brassai et al., 2011; Wnuk, 2021), including longitudinal research into outcomes and recovery pathways (Rubio et al., 2018). The literature review found that, as far as can be ascertained, the Purpose in Life test has only been used once to measure these concepts in late-onset problem drinkers (see Adams & Waskel, 1991a). That said, it has been widely employed in the context of alcohol research generally (Cranford et al., 2104; Marsh et al., 2003; Song et al., 2018) as well as the treatment of AUD/alcohol misuse (Waisberg & Porter, 1994; Witkiewitz et al., 2021). These two measures then, i.e., the Purpose in Life test test and the MLQ, both of which were developed to measure MPL, were considered the most appropriate scales, to measure the construct in older adults experiencing AUD/problematic drinking, and contribute towards answering, along with the research's qualitative data, research questions 3 and 4, which explore the role of MPL, in both early- and late-onset problem drinkers, both when they were drinking and in recovery.

3.6.2 Purpose in Life test (Crumbaugh & Maholick, 1964)

The Purpose in Life test (Crumbaugh & Maholick, 1964), discussed briefly in chapter two, is a reliable and valid 20-item, seven-point attitude scale that ranges from low purpose to high purpose (Figure 3.2). The Purpose in Life test was developed specifically to measure Frankl's concepts of a noögenic neurosis and an existential vacuum (Frankl, 1963; 1966; 1968; 2014), i.e., 'the degree to which the subject experiences a sense of meaning and purpose in life'

(Crumbaugh, 1968, p. 74). The total score of the 20 items, reflects the subject's degree of *purpose in life*, i.e., the higher the score, the higher the subject's *purpose*. The Purpose in Life test's development was further encouraged by a quantitative critique (Kotchen, 1960), that had questioned the relationship between poor mental health and existential concepts, such as Frankl's. In response to the criticism, the Purpose in Life test was designed on the "unorthodox principle" that, while theoretically, a person cannot explain their attitudes precisely, particularly in relation to the subject herein, i.e., *purpose in life*, they will be able to describe a reliable enough account of their feelings on the subject (Crumbaugh, & Maholick, 1964, p. 202). The authors further argued that if their assumption proved to be wrong, it would be apparent "in low reliability and in low validity as measured against an operational criterion of either mental health or *life purpose*".

The 225 participants in the original Crumbaugh, & Maholick (1964) manuscript, consisted of two control groups, two groups of psychiatric outpatients and a group of hospitalised alcoholics. There was significant discrimination between the psychiatric outpatient and alcoholic groups and the control groups. Additionally, mean scores declined progressively among the control groups, through the psychiatric outpatients, finally, to the alcoholic group; this was "consistent with predictions from the orientation of *construct validity*" (p. 204). The authors concluded by pointing out that their study was "heuristic and exploratory and not definitive" (p. 207). Using the same sample that had been investigated in the original manuscript (Crumbaugh, & Maholick, 1964), Crumbaugh (1968) later cross-validated the Purpose in Life test. Two items were dropped, and the remaining 20 Purpose in Life test items, as they appear now, were tested again for their psychometric properties, which were found to be "a reliable and valid measure of Frankl's conception of MPL, and the results favour the correctness of his formulations in logotherapy" (p. 80). Several other studies have explored the psychometric properties and construct validity of the Purpose in Life test.

Marsh et al. (2003) found that the Purpose in Life test demonstrated high internal consistency, α = 0.9. Reker and Cousins (1979) found that Purpose in Life tes scores were positively related to present life satisfaction and positive future expectations, while Harlow et al. (1987) reported that PIL scores were positively related to happiness. The internal consistency and temporal stability reliabilities of the Purpose in Life test have been reported too, i.e., split-half reliabilities of .92 (Crumbaugh, 1968) and .87 (Reker, & Cousins, 1979). Additionally, test-retest reliabilities have been reported, i.e., .83 (Meier, & Edwards, 1974), .79 (Reker, & Cousins, 1979). Marsh et al. (2003, p. 869) point out that although the studies that have investigated the Purpose in Life test's factor structure (confirmatory and exploratory), "have found a single dimension for the scale", they are limited in number and further exploration of the scale's structure "when used with various groups" is required.

Figure 3.2.

Purpose in Life test (Crumbaugh & Maholick, 1964).

Items		1 2 3 4 5 6 7	
		Low purpose	Neutral	High purpose
1.	I am usually:	Bored	Enthusiastic.
2.	Life to me seems:	Completely routine;	Always exciting.
3.	In life I have:	No goals or aims;	Clear goals and aims.
4.	My personal existence is:	Utterly meaningless, without purpose;	Purposeful and meaningful.
5.	Every day is:	Exactly the same;	Constantly new and different.
6.	If I could choose I would:	Prefer never to have been born;	Want 9 more lives just like this one.
7.	After retiring I would:	Loaf completely the rest of my life;	Do some of the exciting things I've always wanted to do.
8.	In achieving life goals, I have:	Made no progress whatsoever;	Progress to complete fulfilment.
9.	My life is:	Empty, filled only with despair;	Running over with exciting things.
10.	If I should die today, I'd feel that my life has been:	Completely worthless;	Very worthwhile.
11.	In thinking of my life, I:	Often wonder why I exist;	Always see reasons for being here.
12.	As I view the world in relation to my life, the world:	Completely confuses me;	Fits meaningfully with my life.
13.	I am a:	Very irresponsible person;	Very responsible person.
14.	Concerning freedom to choose, I believe humans are:	Completely bound by limitations of heredity and environment;	Totally free to make all life choices.
15.	With regard to death, I am:	Unprepared and frightened;	Prepared and unafraid.
16.	Regarding suicide, I have:	Thought of it seriously as a way out;	Never given it a second thought.
17.	I regard my ability to find a purpose or mission in life as:	Practically none;	Very great.

18.	My life is:	Out of my hands and controlled by external factors;	In my hands and I'm in control of it.
19.	Facing my daily tasks is:	A painful and boring experience.	A source of pleasure and satisfaction.
20.	I have discovered:	No mission or purpose in life;	A satisfying life purposes.

3.6.3 MLQ (Steger et al., 2006)

The second measure, the MLQ (Steger et al., 2006) is a ten-item measure using a seven-point scale, ranging from 'Absolutely Untrue' (1) to 'Absolutely True' (7). Divided into two subscales of five items (see Figure 3.3), the scale measures two psychological constructs: a *presence of meaning*, that is, how much meaning the respondent feels is *present* in their life, and a *search for meaning*, which measures to what degree the respondent is *searching* for meaning in their life. The MLQ has good internal consistency, convergent/discriminant validity, and test–retest stability (Steger et al., 2006). Further, both subscales have good internal reliability; presence, $\omega = 0.91$, search $\omega = 0.91$ (Copeland et al., 2020). In common with the Purpose in Life test, the MLQ has been used extensively on the general population of people who experience problematic drinking (Copeland et al., 2020; Kleftaras & Katsogianni, 2012; Sliedrecht et al., 2022). However, as far as can be ascertained, the scale has not been used in the context of late-onset AUD/problem drinking. That the Purpose in Life test and the MLQ have been used comprehensively used in the context of the general population of problematic drinkers, supports their usage in the current research.

Figure 3.3.

Meaning in Life Questionnaire (Steger et al., 2006).

Please take a moment to think about what makes your life feel important to you. Please respond to the following statements as truthfully and accurately as you can, and please remember that these are subjective questions and that there are no right or wrong answers. Please answer according to the scale below.							
	Absolutely Untrue	Mostly Untrue	Somewhat Untrue	Can't Say True or False	Somewhat True	Mostly True	Absolutely True
	1	2	3	4	5	6	7
1	I understand my life's meaning.						
2	I am looking for something that makes my life feel meaningful.						
3	I am always looking to find my life's purpose.						
4	My life has a clear sense of purpose.						
5	I have a good sense of what makes my life meaningful.						
6	I have discovered a satisfying life purpose.						

7	I am always searching for something that makes my life feel significant.	
8	I am seeking a purpose or mission for my life.	
9	My life has no clear purpose.	
10	I am searching for meaning in my life.	
Presence and Search subscales:	Presence = 1, 4, 5, 6 & 9-reverse-coded	Search = 2, 3, 7, 8 & 10

3.6.4 Demographic Questionnaire

Demographic data is a central and important feature of any study, and a fundamental component of the basis of the statistical data generated by quantitative investigation, and to a lesser degree, qualitative data. The demographic questions (Figure 3.4) were tailored to the population being investigated, in this instance, older problematic drinkers. For example, along with the standard demographic questions such as, age, gender, sexual identity and relationship status, there is a question that enables early- and late-onset problem drinkers to be identified. The question which asks the respondent, 'What age do you think you were when your drinking became problematic?', gives the respondent nine age options, increasing every five years, beginning with 'before 30' and concluding with 'after 65'.

Moreover, the demographic information in the current research is essential in answering fundamental questions such as: Are there gender differences between early- and late-onset problem drinkers? Is there an association between the method of recovery (e.g., mutual-aid group) and length of sobriety? Additionally, and importantly, demographic information is fundamental in supporting the research's qualitative data to answer the research question that '*investigates and compares the psychosocial characteristics of people in recovery from late-onset AUD/problem drinking, with the psychosocial characteristics of people in recovery from early-onset AUD/problem drinking*', and to a lesser degree, the question '*when they were drinking*' (e.g., What age do you think you were when your drinking became problematic?). Furthermore, and again, supporting the qualitative data, the demographic data, helps to address the question that 'investigates and compares the recovery pathways of people with late-onset AUD/problem drinking, with people with early-onset AUD/problem drinking'.

Figure 3.4. *Demographic questionnaire.*

☐ **What is your age?**

Gender	**Sexual Identity**	**Relationship status**
☐ Female	☐ Gay	☐ Married/cohabiting
☐ Male	☐ Straight	☐ Divorced/separated
☐ Other	☐ Other	☐ Widowed
☐ Prefer not to say	☐ Prefer not to say	☐ Single

What age do you think you were when your drinking became problematic?

☐ Before 30 ☐ 30-35 ☐ 35-40 ☐ 40-45 ☐ 45-50 ☐ 50-55 ☐ 55-60 ☐ 60-65 ☐ After 65

Through which organisation did you find recovery?

☐ Alcoholics Anonymous
☐ Smart Recovery
☐ NHS.
☐ Other (please enter organisation name in box) ☐

How many years have you been in recovery? ☐

Spirituality/Belief system *(Please indicate which of the following best applies to you?)*

☐ Religious ☐ Belief in a concept of God but not religious
☐ Spiritual, i.e., your life philosophy is not based on a divine being/deity/God ☐ Secular

3.7 QUALITATIVE METHOD.

Guided by Frankl (2014), who stated that logotherapy is an adaption of "the phenomenological methodology" (p. xvi), and the experience of previous research on the lived experience of people in recovery from AUD/problem drinking (e.g., Kime, 2018; Medina, 2014; Shinebourne & Smith, 2009; 2011), interpretative phenomenological analysis (IPA), was considered to be the most appropriate method of investigation for the qualitative component of the thesis. Because IPA is such a central feature of the thesis, it is necessary to explain IPA's theoretical underpinnings and method.

3.7.1 IPA

IPA Theory

The philosophy of phenomenology, or transcendental phenomenology (Husserl, 1999), is concerned with how human beings perceive and experience things (phenomena), as they arise in the world; this way of experiencing the world, can be described as the phenomenological attitude. The *phenomenological attitude* is in direct opposition to the *natural attitude*; naturalism views all phenomena as belonging to the natural world and as such, all things can be explained rationally by empirical investigation. Phenomenology, however, is concerned with the study of consciousness, rather than the scientific study of nature; phenomenology is about studying how human beings experience the world "within contexts and at particular times, rather than in abstract statements about the nature of the world in general" (Willig, 2013, p. 51). IPA, which is adapted from Husserl's pure form of phenomenological enquiry (Smith et al., 2009), has additionally, appropriated many of the ideas of existential phenomenological philosophy, and its leading figures, including Heidegger (1977), Merleau-Ponty (2013) and Sartre (1960).

Developed by Jonathan Smith relatively recently as a qualitative thematic method for use, specifically in health psychology, and the social sciences more generally (Smith, 1996; 2004), IPA is the combination, or point of convergence of an eclectic mixture of three philosophies; phenomenology itself, hermeneutics, and idiography. Phenomenology, as discussed, is concerned with "the things themselves" (Husserl, 1900, p. xxviii), as they are perceived and experienced by the observer, independent of either, metaphysical or theological accounts to explain the observed phenomenon. Hermeneutics, in its broadest term, is the theory of interpretation, usually of discourse and text, but more specifically, the interpretation of sacred (e.g., biblical) and philosophical texts (Audi, 1999). It is the hermeneutic phenomenology advanced by Heidegger (1977) that best describes how hermeneutics is

assimilated into the IPA method. *Dasein,* a German word for existence, is a central feature of Heidegger's existential hermeneutics, which literally translated means *being there* or *presence*. Central features of *Dasein* are "lived time and engagement" (Smith et al., 2009, p. 23), which Heidegger emphasised are always accessed via interpretation (Smith et al., 2009). Idiography then, is the final, influential component to inform the IPA method of enquiry. Idography is concerned with the *particular*; that is, it's focus is on the individual and their meaning making of a particular event or experience (phenomenon).

IPA Method *(applied to the current research)*

The main aim of any research employing the IPA method is to explore in detail the lived experience of its participants, regarding a specific event (phenomenon) and how the participants think and feel about the phenomena and the processes related to it (Smith & Nizza, 2022). Additionally, IPA seeks to elicit the participants' subsequent *meaning making* of the phenomenon, and how they make sense of it (Smith et al., 2009). The participants' thinking, manifested in their discourse, "is an aspect of Being-in-the–world and not simply detached disembodied cognitive activity" (Eatough & Smith, 2017), echoing IPA's theoretical concern with exploring consciousness. According to Smith et al. (2009, p. 51), the researcher undertaking the analysis should produce "rich, transparent and contextualised" interpretations of the participants' discourses. Analysis involves the practical application of the three underpinning philosophies of IPA theory (phenomenology, hermeneutics, and idiography). In the first instance, and from a phenomenological perspective, the researcher should cultivate and nurture the 'phenomenological attitude', achieved by applying a process of eidetic reduction, that involves bracketing (*epoché*) the natural attitude. This reductive technique means that the researcher using IPA must disregard or push aside (bracket) any knowledge they have regarding the 'phenomenon' being investigated, so that any pre-conceived prejudices and judgements can be, at best avoided, or at least limited in their influence.

Employing an idographic approach, the IPA researcher investigates the minutiae of individual cases. That said, the detailed analysis of a single case can be adapted effectively for multiple, individual cases of homogenous groups who share a common event or experience. These can then be compared, allowing the similarities of multiple individual cases to converge, from which patterns of commonality (experiential themes) of the observed phenomenon emerge and are identified (as in the current research). The final phase of analysis of the participants' discourse in an IPA study, is the interpretative phase, informed by the final theoretical influence, hermeneutic interpretation. IPA views people as sense-making beings and the participants' discourse reflects their personal interpretation of their experience, which the researcher must then interpret. Referred to as a 'double hermeneutic' (Pietkiewicz & Smith, 2014), in essence, it involves a dynamic process, whereby the researcher attempts to make sense of the participants' own sense-making; it is a central feature of the "hermeneutic circle of the research process" (Smith et al., 2009, p. 35).

Finally, it should be emphasised that IPA is a reflective and iterative process, at every stage of the research project. This means that from the initial stage of developing an interview schedule, through the analytical stage of note taking and identifying experiential statements and themes, to the final write-up of the project, which typically requires multiple drafts and edits. However, this is normal, "writing up is part of the analysis, and the analysis is an iterative process" (Smith & Nizza, 2022, p. 62).

3.7.2 Acknowledging different voices

A main aim of the thesis' qualitative component is the recognition and treatment of two, distinct **'voices**': the voice of the '**active**' problematic drinker and the voice of the problematic drinker in '**recovery**'. Both voices have been reported, and can be heard, in a broad body of qualitative work (e.g., Best et al., 2011a; McCormack et al., 2015; McInerney, & Cross, 2021; Morjaria, & Orford, 2002). The two voices are the voices of contrasting emotions. Bowman and Jellinek

(as cited in Kurtz, p. 35, 2002), for example, recognised a link between "emotional maladjustment" and problematic drinkers (the active drinking voice). In contrast, the voice of recovery is about the gradual development of "emotional sobriety" (A.A., 1953, p.116) and nurturing self-worth (Suire, & Bothwell, 2006). However, and as far as can be ascertained, the two voices have yet to be directly compared in the manner undertaken in the current research. Exploring and comparing these contrasting and emotionally polar voices is in line with Smith et al.'s (2009, p. 38) recommendation, that "a good IPA study" should be able to recognise, not only shared themes but also "distinctive voices". Indeed, the interview schedule (*Appendix 3.2*) has been developed to encourage these different voices to emerge and be heard. Moreover, acknowledging different voices, will inform the analysis in such a way, that the "common patterns and idiosyncratic differences within those similarities" can be identified and compared (Smith and Nizza, 2022, p. 51), in accord with the thesis' comparative methodology.

The different voices are presented and discussed over two chapters. The first of these, explores and compares the '**active**' drinking voices of early- and late-onset problem drinkers, while the second considers the voices of both cohorts in recovery. It should be highlighted, however, that because all the participants are in recovery, the accounts relating to active drinking, are retrospective. Recognising these two distinct voices helps to explore the two main features of the research questions, i.e., the psychosocial characteristics of early- and late-onset problem drinkers and the psychological construct of MPL, in the two temporal phases being investigated, i.e., active problematic drinking and recovery. Additionally, recognising two definite voices and treating them as independent entities, acknowledges IPA's commitment to focus on the particular.

3.7.3 Choosing an appropriate method to analyse qualitative data

It is common for IPA researchers in the field of alcohol harm (e.g., Emiliussen, 2017b; 2017c) and health research generally (Philips, 2013, 2014), to use qualitative data analysis software

(i.e., NVivo) to manage the large amount of data that are generated by qualitative methods. Some of the advantages of NVivo include, being able to manage large quantities of data, ease in identifying themes and the ability to manage various types of data (Dollah et al., 2017), other than traditional Word documents (e.g., social media, web pages, spreadsheets, images and videos). A considerable disadvantage of NVivo, however, is the inability to interpret data, a core feature of the IPA method, particularly the interpretative technique of the double hermeneutic, whereby the researcher attempts to make sense of the participants' own attempts of making sense of what is happening to them (Smith, 2019); as far as is known, the technique is not yet able to be replicated by data analysis software.

Moreover, there is the question as to whether the use of software programmes, such as NVivo, have the potential to construct barriers between the researcher and the data they seek to interpret (Bong 2002; Roberts & Wilson 2002), thus removing the human connection, an integral part of all qualitative methods, particularly IPA. Additionally, there is the time-consuming exercise of learning a challenging software programme to a level of proficiency, whereby one feels confident about generating reliable, replicable and plausible data analysis, which meets the phenomenological, hermeneutic and idiographic principles that inform IPA theory (Smith 2011). In contrast, the Chief Investigator is a competent IPA researcher on the topic of recovery from AUD/problematic drinking (McInerney & Cross, 2021; McInerney et al., 2021), who feels confident about analysing texts that relate to human experience using conventional manual methods. As Martin and Sugarman point out (2001), "Events as experienced by human agents carry significance. They matter, and humans are consequently not indifferent to, but interactive with, them" (p. 193).

The amount of data, along with the qualitative method being used, is another major factor to consider when choosing between software and manual methods, and at 18 interviews, the current study was felt to be a manageable enough amount of data for manual analysis.

A good IPA study needs to capture the essence of what it means to be human (Smith et al., 2009), and it is, therefore, essential to choose the most appropriate method to achieve that aim. After considering the literature (Bergin, 2011; Dollah et al. 2017; Wagstaff et al., 2014), and reflecting on the advantages and disadvantages of NVivo, along with personal strengths and weaknesses, the author decided to undertake analysis and interpretation of the corpus of the current study, using the more traditional manual method, unaided by data analysis software. A comprehensive explanation of the method of analysis is included in the method section of chapter four (this is also applicable to chapter five).

3.8 PILOT TESTING DATA COLLECTION MATERIALS

Reflexivity is an important and integral part of any research project. This is especially relevant in the context of the current research, because of its investigative IPA framework and the technique of bracketing, putting aside one's feelings and opinions about the topic being investigated. Because the author has an 'insider' perspective in relation to the research topic, the reflective process was more challenging. To address the insider dynamic and become aware of any preconceptions and opinions held, the author was himself interviewed by a friend, using the interview schedule, before interviewing others, which gave him a better understanding of the interview questions from the perspective of the interviewee.

All the materials used in the current research were then pilot tested on the sample population being investigated and amended if and where necessary. For instance, two members of A.A. were interviewed initially, and it became apparent that some questions needed amending, or even deleting. Thus, the interview schedule underwent an evolutionary process to validate the interview data (*Appendix 3.2*). Validation involved not only feedback and discussion with the interviewees, but also further reflection of the author's own 'insider perspective', and the subsequent interviewee-interviewer dynamic. This process allowed for the interview schedule to be amended/edited until it was considered valid for using in the main

body of research (*Appendix 3.2*). Additionally, the subsequent research interviews were carried out online, and the pilot interviews, presented an opportunity to test the appropriateness of the medium, e.g., the correct recording levels.

The Purpose in Life test, the MLQ and the demographic questionnaire were piloted on 15 members of A.A. at the 2022 London International Convention. As discussed, the Purpose in Life test and the MLQ are reliable and valid measures, and it was felt that a CFA was not necessary. However, the interviewees were asked how they felt about the questionnaires, e.g., length of questionnaires, understanding and suitability of questions; the feedback was positive. That said, based in part, on interviewee feedback, the piloted demographic questionnaire (*Appendix 3.3*) was comprehensively edited for the final version. For example, the final question, about spiritualty/belief system, at the end of the questionnaire, which had three choices/options in the piloted version, has had a fourth choice added: *Belief in a concept of God but not religious*. The overarching purpose of the interview schedule was to understand why some individuals, who have drunk moderately for most of their lives start drinking excessively and problematically later in life. For the evolution/development of the interview schedule, please refer to *Appendix 3.2* in the appendices section at the end of the thesis (after the references)

3.9 RECRUITMENT

3.9.1 Sampling method

The sampling method used by the current research, broadly speaking, can be referred to as 'representative, non-probability sampling'. Firstly, it is representative of specific demographic sub-groups within the wider, early- and late-onset problematic drinking populations (i.e., people of 50-years-old and older). All the recruitment information (print and digital), for example, stipulated that the requirements for participation was people of 50-years-old and older in recovery, whose drinking became problematic either at the age of 50 or later (late-onset), or

people whose drinking became problematic earlier in life (early-onset) and was, therefore, representative of the specific demographic sub-groups i.e., early- and late-onset problematic drinkers. Secondly, the sampling method is deemed to be non-probable. Whereas probability sampling, has the potential to present everyone within the target population an equal opportunity of being selected, non-probability sampling does not afford everyone within the same population, the equivalence of opportunity to undertake the survey, as is the case herein. This is because the primary recruitment methods (e.g., Facebook groups, recovery-orientated organisations) were representative only of the people who are affiliated to the groups and organisations who were contacted; not all people in the target population are members of recovery-orientated organisations or Facebook groups. This sampling method, however, has the flexibility to recruit enough people to undertake the survey and generate enough data to produce statistically significant conclusions and other robust statistical methods and tests, as determined by a GPower analysis. A GPower analysis of a between groups t-test found that a sample size of 128 (64 per group) would be needed to produce a medium effect size (0.5). Refer to *Appendix 3* for GPower analysis and parameters. (It is worth noting that the final sample size was 381: 249 early-onset and 132 late-onset).

3.9.2 Mitigating against recruitment biases

People in recovery, particularly members of mutual-aid groups, such as Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) typically assume a social identity related to the organisation to which they are affiliated (Best et al., 2016; Frings et al., 2016). Indeed, evidence suggests that adopting a social identity, such as that of a 'recovering alcoholic', for example, not only supports recovery, but can prevent relapse too (Buckingham et al., 2013). However, group identity, typically leads to the development of in-group favouritism and in-group biases (e.g., Billig & Tajfel, 1973; Molenberghs, 2013), and can mean that the narratives and behaviour of people in recovery from drug and/or alcohol misuse, can be profoundly

influenced by the tenets of the recovery organisation to which they are affiliated (Galanter, 1990), and the discursive lexicons they acquire through their membership (Williams, 2021). To mitigate against in-group bias and capture a more diverse selection of 'recovery voices', an 'eclectic attitude' towards recruitment was adopted. This involved inviting participants from a broad spectrum of recovery-orientated organisations, including the NHS. Socioeconomic status (referred to in the following chapters) is another bias that is relevant in the context of the current thesis, however it is difficult to control for. This is because compared to people considered to be from a lower socioeconomic status, individuals considered to be from a higher socioeconomic status, are more likely to volunteer for research (Nikolopoulou, 2022). At this point, therefore, it is worth defining socioeconomic status and how it is measured.

Defining and measuring socioeconomic status

Broadly speaking, the thesis frames socioeconomic status within the definition provided by American Psychological Association (2023): "Socioeconomic status encompasses not only income but also educational attainment, occupational prestige, and subjective perceptions of social status and social class. Socioeconomic status encompasses quality-of-life attributes and opportunities afforded to people within society and is a consistent predictor of a vast array of psychological outcomes." As such, the socioeconomic status of the participants in this thesis is based (measured) on three variables: 1) perceived income/wealth, 2) educational attainment, 3) occupation.

3.9.3 Social capital in the context of recovery

The concept of social capital is referred to on numerous occasions in the following chapters. Because social capital can be a factor on socioeconomic status, it will prove useful here to define social capital so that it is contextualised appropriately in relation to this thesis generally and more specifically, recovery. Bourdieu (1986) who developed social capital theory, defined social capital as the "aggregate of the actual and potential resources which are linked to

possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition – or in other words, membership in a group" (Bourdieu, 1986, p. 249). In plain language, and importantly, in the context of recovery, social capital simply translates, and is measured as, the total social resources that are available and accessible to the individual. In a generic sense this can be viewed as social relationships. More specifically, social capital (resources) can take the form of a supportive and stable family, social networks, social groups and access to and membership of institutions. One can see how important social resources are in the context of recovery. Indeed, Cloud and Granfield (1994, 2001), who developed the concept of recovery capital, have written extensively about social capital (Granfield & Cloud, 2001) and many of the domains within the framework can be directly attributed to social capital theory. More recently, White and Cloud (2008) have even defined a *social recovery capital* model of recovery, which is discussed in detail in chapter five.

3.9.4 Recruitment procedure

Phase 1

There were two sources of recruitment across the two phases (quantitative and qualitative). The purpose of the initial, first, phase (quantitative), was to recruit potential participants to undertake the online questionnaires. Initially, an introductory letter (*Appendix 3.4*), outlining the research and the demographic being investigated was sent to several recovery-orientated organisations (*Appendix 3.5*). Organisations were selected based on the author's knowledge of notable recovery organisations, as well as recommendations from other researchers in the field of recovery. The letter invited the organisations to direct potential participants who were in recovery to the survey. An invitation to participate/information sheet (*Appendix 3.6*) and an A4 recruitment poster (*Appendix 3.7*) accompanied the letter, both of which included a QR code, that when scanned, takes the participant directly to the online survey. Additionally, a summary of, and link to the survey (*Appendix 3.8a*) were posted on numerous 'recovery-focussed'

Facebook groups (*Appendix 3.8b*). The Facebook groups were continually reviewed, and the research summary text and survey link, inviting people to participate in the survey, was regularly re-posted so that it appeared at the top of the page to achieve a better response rate.

Phase 2

Interview participants were recruited from the survey phase. At the end of the online survey, participants are invited to take part in the second phase of the research by leaving their email address in a box provided for this purpose. The Chief Investigator contacted those who were interested to arrange a convenient time to be interviewed.

N.B. Much of the minutiae recruitment procedures of each of the two phases of the research is described in the methods section of each of the relevant qualitative and quantitative chapters.

3.9.5 Defining early- and late-onset participants

The literature review undertaken in the previous chapter, approximated, cautiously, that late-onset problematic drinking is likely to emerge at around the age of 50-years old. That said, the review further recommended that "*a standardised cut-off age would be determined by the research undertaken in the main body of this thesis*." As such, the ages for early- and late-onset participants in the thesis will be determined in chapter six, (the quantitative component of the thesis). Therefore, the cut-off ages for early- and late-onset participants will be quantified on analysis of the data harvested from the following demographic question in the survey: 'What age do you think you were when your drinking became problematic?' The rationale for the decision to categorise two onset-types only, rather than more than two, was based on the following criteria. Firstly, the onset-type categorisations of the 26 papers reviewed; 12 papers categorised two-onset types, and a further seven papers categorised late-onset or very late-onset only, although these papers did refer to an early-onset category in their texts. Thus, 19 of the 26 papers viewed problematic drinking onset-type from a dichotomous perspective. The second consideration is that it is useful for the health and social care professionals who are most likely

to encounter late-onset problem drinkers, to simply be aware that there is a group of older problem drinkers.

It is important to note that the approximate cut-off age for late-onset problem drinking established in the literature review was quantified, based on the mean age of late-onset reported in 26 papers over a 34-year time span (1985-2019), where a wide age-range for late-onset existed (between >40-years old and ≥60-years old). In contrast, the mean age for late-onset problem drinking used in chapters four, five and six is representative of the quantified analysis of the data reported by the participants who responded to the survey.

3.9.6 Defining a concept of recovery for the sample population

The current research compares two distinct cohorts, early- and late-onset problematic drinkers. As noted above, the literature review approximated that late-onset AUD/problematic drinking is likely to emerge at around 50-years-old. Therefore, the recruitment profile was people of 50-years-old or older, in recovery from AUD/problem drinking. Although age can be easily enough construed, recovery is a more difficult and abstract concept to define, because recovery is about more than just not drinking (total abstinence), or alternatively, moderating alcohol consumption, something which has been considered by some researchers (e.g., Fan et al., 2019; Witkiewitz & Tucker, 2020; Witkiewitz et al., 2020). It is necessary, therefore, to define what recovery means in the context of the current research.

The National Institute on Alcohol Abuse and Alcoholism's (NIAAA; Hagman et al., 2022) recent, and extremely wordy definition of recovery, did not view abstinence as an essential requirement of recovery either, but rather, used the ambiguous phrase, "*cessation from heavy drinking*", adding that, "*recovery is often marked by the fulfilment of basic needs, enhancements in social support and spirituality, and improvements in physical and mental health, quality of life, and other dimensions of well-being*" (p. 808). The qualitative data on which the definition was based, were provided by "key recovery stakeholders" that included

"researchers, clinicians and recovery specialists" (Hagman et al., 2022, p. 808). However, it can reasonably be argued that a fully informed definition of recovery should also include input from those with lived experience of recovery from AUD/problematic drinking, something that has been acknowledged by other researchers.

With the above in mind, Laudet's (2007) definition, which was informed purely by the discourses of people who identified as being in recovery, is worthy of consideration. Laudet (2007) found there was a significant association between people who had been exposed to treatment and to12-step programmes and abstinence as a goal recovery. Moreover, people who did and did not view themselves as being in recovery, believed that abstinence was an essential component of defining recovery. That said, they also viewed recovery as being about so much more than abstinence, i.e., "*a process of self-improvement and an opportunity at a new and better life*" (p. 251). In common with Laudet's (2007) definition, White's (2007) definition of recovery, highlights the experiential nature of recovery:

> "*Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by alcohol and other drug-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life*" (p. 236).

Again, White's (2007) definition, makes no references to abstinence as a part of the process of recovery, the focal point instead, being on the resources (both internal and external) that support recovery, i.e., RC (Granfield & Cloud, 1999). White's (2007) definition helped to inform the Betty Ford Institute Consensus Conference (Panel, T.B.F.I.C.P, 2007), whose purpose was to develop a standard, working definition for recovery. The Consensus presented the following succinct definition of recovery as "*a voluntarily maintained lifestyle comprised*

of sobriety, personal health and citizenship" (p. 221). Moreover, in common with Hagman et al.'s (2022) ambiguous use of language, the Consensus' inclusion of *sobriety*, can be interpreted as referring to either, *temperance/moderation* of alcohol consumption, or someone classified as addicted to alcohol, who *abstains* from drinking.

Prominent advocates of the RC model of recovery (which itself does not make assumptions regarding abstinence), Best and Hennessey (2022), summarise the varying explanations of recovery (many of which are outlined above) as, "a continuum of definitions, some of which include abstinence and/or sobriety from substances and others which focus more broadly on life functioning and well-being" (p. 1139). Nonetheless, for many problematic drinkers, their lived experience has shown them that they are unable to moderate their alcohol consumption and drink safely and have accepted that total abstinence is essential to their recovery.† That said, *abstinence* is not referred to in any of the current research's recruitment literature, as a participatory requirement for the current research. For instance, the preamble to the online questionnaires from which the research data were gathered reads:

To participate in the research, you must be 50 years-old or older

AND

Either a *late-onset* drinker in recovery (someone whose drinking became problematic approximately at around the age of 50 or later), OR an early-onset drinker in recovery (someone whose drinking became problematic earlier in life).

In broad terms, therefore, the current research's understanding of recovery is informed by the domains described in the definitions outlined above. Particularly, T.B.F.I.C.P's (Panel, 2007) reference to *citizenship*, something which echoes the sentiment of A.A.'s founder Bill Wilson (1967, p. 18), who had stated that, "In A.A. we aim not only for *sobriety* — we try again to become *citizens* of the world that we rejected, and of the world that once rejected us".

[†]The author's thoughts and reflections on the concept of recovery, from a personal, lived experience perspective, are presented in the discussion chapter at the end of the thesis.

3.10 OTHER METHODOLOGICAL CONSIDERATIONS

3.10.1 Avoiding stigmatising language: using a person-centred language

The literature review identified an association between stigmatising language and late-onset drinkers. Historically, stigmatising terminology, such as *late-onset alcohol abusers* (Schonfeld et al., 1987), has been used to describe the late-onset problematic drinking population investigated in this thesis. The use of the word *alcoholic*, for instance, was found to be particularly stigmatising (e.g., *late-onset alcoholics;* Adams & Waskel, 1991a), especially by women late-onset drinkers (Brennan and Moos, 1991; Wadd et al., 2011), and is known to prevent them seeking help/treatment (e.g., Emiliussen et al., 2017b), highlighting the negative impact that stigmatising language has on people. Moreover, it also highlights the power and importance of language, language has meaning.

The current thesis, therefore, makes an earnest attempt to frame its discourse within a non-stigmatising, more person-centred language. A 'people-first' language (White, 2001, p. 7) aims to avoid pathologizing problematic drinking and focusses on a therapeutic language that supports and promotes recovery. Wilson (2020), who also supports the notion of a recovery-promoting, person-centred language, assumes a philosophical position regarding the language of recovery, that is in accord with the theoretical framework of this thesis, i.e., the notion that, 'Recovery is about engaging in a life that has meaning and purpose' (p. 156/157). Using the person-centred term *late-onset AUD/problem drinker*, instead of *late-onset alcoholic*, promotes a more inclusive recruitment process, which has the potential to attract a wider range of people who have experienced problems with alcohol, and not merely those who are comfortable to accept being identified by a pathologising terminology.

3.10.2 An 'insider perspective' — reflections on a methodological challenge

> On the one hand, advocates for the outsider perspective generally argue that access to authentic knowledge is more obtainable because of the objectivity and scientific detachment with which one can approach one's investigation as a non-member of the group. On the other hand, proponents of the insider perspective claim that group membership provides special insight into matters (otherwise obscure to others) based on one's knowledge of the language and one's intuitive sensitivity and empathy and understanding of the culture and its people. (Kikumura, 1986, p. 2)

The benefits and pitfalls of an insider perspective compared to an outsider perspective, will understandably, remain an ongoing debate in the social sciences; Kikumura's (1986) insightful summary offers a balanced starting point to reflect on this methodological challenge. As the author of this thesis, it is important, indeed necessary, that I disclose my relationship with the thesis' topic and population investigated herein. I felt, therefore, that it was essential for me to reflect and comment on this relationship, pre- rather than post-data analysis. Although the thesis aims to use a less stigmatising, more inclusive, alcohol-harm-related language, I am comfortable to disclose that I am in recovery from 'alcoholism'. My sobriety date is 14 August 1990; one never forgets their sobriety date, it is after all, a re-birth, and a reason to celebrate. It could be argued that being an 'insider', and having a 'group' connection, potentially, gives one greater access to the participants' narrative, than a researcher with an outsider perspective might have (Rabe, 2003).

On the other hand, and within an IPA context, having an insider perspective could quite legitimately be viewed as being more of a handicap than a benefit, for the researcher. This is because the researcher's ability to practice the essential IPA technique of epoché (bracketing), i.e., disregarding and pushing aside that which one knows about the phenomenon being investigated, becomes compromised and is more difficult to practice. Therefore, one must acknowledge these challenges to be able to mitigate against them. To control for this

methodological conundrum, I refer to Smith et al. (2009), who advise that, "the positive process of engaging" with a participants' discourse, should supersede any concerns over bracketing, in the knowledge that "skilful attention to the former facilitates the latter" (p. 35).

3.10.3 Ethical approval

As discussed above, data for this thesis was collected from several organisations including the NHS. In the first instance, ethical approval for the research undertaken was granted by:

The College of Business, Law and Social Sciences Research Ethics Committee, at the University of Derby. Application ID: ETH2122-2604 (*Appendix 3.9*).

Additionally, further ethical approval for the research undertaken was granted by:

The NHS Health Research Committee (HRA) Research Ethics Committee (REC).

- REC reference 22/EM/0162s
- Integrated Research Application System (IRAS) project ID: 314610
- Favourable Opinion Letter (*Appendix 3.10a*).
- HRA Approval Letter (*Appendix 3.10b*).

CHAPTER FOUR

THE 'ACTIVE' DRINKING VOICE

…. but I had no control and no power. I just, you know, it was just like, I was like a moth hitting a light bulb. (Kerry, late-onset)

4.1 INTRODUCTION

The sharing of personal narratives is a central feature of recovery from problematic drinking. The healing power attributed to sharing one's personal story in recovery can be traced back (at least) to 1840 and the *Washingtonian Total Abstinence Society*: "an hour or so would be spent in the recital of their experiences by such members of the society as felt inclined to speak" (Arthur, 1865, p.34). A body of literature has explored the narratives of individuals in recovery from AUD/problem drinking (e.g., Momper, et al., 2017: Rayburn, 2014; Shinebourne, & Smith, 2009), though mainly from an A.A. perspective (e.g., Bond, & Csordas, 2014; Glassman et al., 2022; Weegmann, & Piwowoz-Hjort, 2009). Indeed, there has been more than enough research in this area, to warrant critical, systematic reviews on the topic (Glassman et al., 2020; Subhani et al., 2021). The narratives of the 'active' problem drinker too, have been reported in a broad body of work, but again, many of these have been in the context of the A.A. programme (e.g., Christensen, & Elmeland, 2015; Flaherty et al., 2014; Humphreys, 2000), and similarly to the narratives in the current chapter, they are mostly retrospective accounts.

Humphreys (2000), for example, identified five narrative categories in A.A. stories, foremost among these being the *drunkalogue*. According to Humphreys (2000, p. 498), the drunkalogue is "the most important story form in Alcoholics Anonymous" and is typical of many of the 'shares' heard at most A.A. meetings, which for the most part, are homogenous in content (Steffen, 1997). A.A.'s twelfth step, the principle of sober A.A. members helping those who are still drinking problematically, is predicated on the notion of identification through the

shared experience of problematic drinking and it is the A.A. member's active drinking story that the problem drinker identifies with (e.g., A.A., 2001; Galanter et al., 2023; Swora, 2004; White, & Kurtz, 2008). The mutual identification that emerges from the sharing of drunkalogues is an empathetic process that is, partly, about building a shared social identity in the group. Additionally, the process is reciprocal, not only does the problematic drinker receive support, but the sobriety and recovery[1] of the A.A. member who shares their story with the problematic drinker is reinforced (Best et al., 2016; Lederman, & Menegatos, 2011).

In contrast to the active problem drinking voice, viewed from the retrospective position of recovery, Eriksen and Hoeck (2021) explored the narratives of socially excluded problem drinkers in 'real time', that is, individuals who were still drinking problematically. The sample were all male, aged between 49-64, who admitted to participating in a "large consumption of alcohol" (p. 78). The authors found that the participants' active drinking narratives constructed alcohol as "a life companion with a double meaning" (p. 80), that reflected both, negative (e.g., fear, remorse) and positive (e.g., fellowship, joyful memories) associations with alcohol. Interestingly, they also found that different participants constructed diametrically opposing identities; either accepting or rejecting the identity of a stereotypical 'drunk', thus highlighting the individual nature of both, human meaning making, and identity construction.

Many researchers have reported that the reconstruction of identities, both personal (DePue et al., 2014; Irving, 2011; Lederman, & Menegatos, 2011; Sawyer et al., 2020) and social (Best et al., 2016; Buckingham et al., 2013; Frings et al., 2016) are notable features of people in recovery, and are often contained within their retrospective accounts. This reconstruction of identities is a direct response to the "cognitive shift from drinker to non-drinker" (DePue et al., 2014, p. 38), a dynamic process of identity transformation that inform the positive attitudes (Best et al., 2011; Best et al., 2016) of a new (Steigerwald, & Stone, 1999) and evolving language (e.g., Christensen, & Elmeland, 2015) that typically emerges in

recovery. It is a positive language, diametrically opposed to the negative language associated with active, problem drinking (Marengo et al., 2019; Van Swol et al., 2020).

Moreover, the healing property of storytelling is much more than a theoretical construct, it has a practical application, in the context of the population in the current research. For instance, *narrative therapy* (Monk et al., 1997; White, & Epston, 1990) has been recommended for older people with alcohol problems as an alternative to "traditional psychotherapy" (Gardner, & Poole, 2009, p. 602). This chapter is the first of two chapters, that explore and compare the two distinct voices of early- and late-onset problem drinkers. Firstly, there is the reflective voice of the 'active' problem drinker, with a retrospective recollection of what they were like, when they were drinking. This is followed by the 'recovery' voice of the ex-problem drinker, recalling what happened to them that made them want to stop drinking, and what they are like now, in recovery.

This chapter focuses on the participants' retrospective, active drinking voices, exploring the similarities and differences between the study's early- and late-onset cohorts. Before discussing the minutia of the methods used in the study, it is important to emphasise, once again, that the participants' active drinking voices are retrospective. Typically, in problematic alcohol and substance use research, data generated from questionnaires and interviews (self-reports), tends to be confounded by two variables, a) memory recall and b) the probability of participants who may "deliberately falsify their answers" (Davies, 1997, p. 83)[2]; the participants in the current study, for instance, may be trying to make sense of where they are now in recovery, compared to when they were drinking. Because the data generated in the current study is retrospective, the former may be the more confounding of the two variables. According to Davies (1997), it can be assumed "that if one could eliminate these two sources of error one would be left with the truth" (p. 83); in reality, however, the truth is that neither variable can be controlled for satisfactorily. The aim of the study is to answer the thesis' first

research question: *Investigate and compare the psychosocial characteristics of late-onset AUD/problem drinkers in recovery and the psychosocial characteristics of early-onset AUD/problem drinkers in recovery when both cohorts were drinking*.

4.2 METHOD

The theoretical framework of the methods used in this chapter and the following one was reported in detail in the previous chapter. The methods section of this chapter focusses on the finer detail of the recruitment process, the participants, data collection and analysis. Moreover, the methods described in this section are applicable to the following chapter.

4.2.1 Sample size and recruitment process

Because of its emphasis on detail, IPA is an extremely time-consuming method of analysis, and therefore, was a major factor in determining the number of participants to recruit, even though the chief investigator is a relatively experienced and published IPA researcher (see (McInerney & Cross, 2021; McInerney et al., 2021). According to Smith and Nizza (2022), for example, a novice IPA researcher, "can invest up to 3 weeks of full-time work" analysing a single interview (p. 16), not including the time spent on transcription. Typically, an IPA study consists of a small homogenous sample of perhaps, five or six participants. Smith and Nizza (2022) suggest that doctoral or post-doctoral researchers might aim for a sample of between 10 to 12. Indeed, Jonathan Smith, the leading figure in the development of IPA, has undertaken research with a sample size of nine (see Osborn & Smith, 1998). Following Osborn and Smith's (1998) example, and because the two cohorts are two distinct, homogenous groups (i.e., early- and late-onset), and effectively two distinct samples, the current research aimed to recruit nine participants for each cohort, a total of 18 participants.

Outlined in the previous chapter, participants for the qualitative phase of the current research were recruited from, and during the quantitative phase of the research, by contacting recovery-orientated organisations (*Appendix 3.5*) and posting a summary of the research

(*Appendix 3.8a*), and link to the survey (*Appendix 3.8b*) on recovery-focussed Facebook groups. Participants who undertook the online survey/questionnaire, and who wished to be considered for the interview phase of the research, were invited to insert their email address in a box at the end of the demographic section of the survey/questionnaire. In total, 46 people (a mixture of early- and late-onset) who declared an interest in participating in the interview phase, contacted by email to arrange a convenient date and time to be interviewed. The Chief Investigator was able to tell whether the potential interviewees were early- or late-onset, according to the information in the demographic form. 25 (55%) of those who were contacted did not respond. Of the remaining 21, two did not turn up for the interview and one cancelled by email, a day before they were due to be interviewed, because of anxiety. When the required number of participants had replied, the invitation to participate in the interview option, was removed from the online questionnaire; this avoided the ethical dilemma of people who were interested in being interviewed, responding to the invitation and subsequentially being disappointed. Participants were sent two copies of the questionnaire information and consent form (*Appendix 4.1a*) to read and sign, returning one to the Chief Investigator. Further, they were encouraged to contact the Chief Investigator about any concerns they had or if they needed further information about the research and/or clarification about the interview, to which they responded accordingly (*Appendix 4.1b*).

4.2.2 Participants

In line with the recruitment strategy of the current research, to mitigate against biases, participants were recruited from a varied range of recovery organisations (*Appendix 3.5*). Additionally, there was a reasonably equal gender split of participants; five women and four men in each cohort. All the participants were assigned pseudonyms.

4.2.3 Categorising early- and late-onset participants

The literature review, recommended that, *a standardised cut-off age will be determined by the research undertaken in the main body of this thesis*. Chapter three (methodology and theoretical framework) reiterated the position, adding that, *the ages for the early- and late-onset participants investigated in the research undertaken in this thesis will be decided on the data collected during the quantitative phase of this thesis, specifically the question in the demographic questionnaire: 'What age do you think you were when your drinking became problematic?'* Therefore, the age categorisations for early- and late-onset participants for this study and the remainder of the research undertaken in this thesis, were determined by that data (see the results section, chapter six).

4.2.4 Data collection

Participants were informed that the interviews would be undertaken online using Microsoft Teams, and that they would be sent a link to the meeting, informing them of the date and time of the arranged interview. Participants were sent a reminder nearer to the scheduled interview date and asked to confirm that they were still available for the interview. Undertaking the interviews, using an online medium, was driven by two factors. Firstly, a health factor; all interviews were carried out during the summer of 2022, when being infected by, or transmitting the COVID19 virus, was still a considerable global health risk. The second factor was a practical one; using online platforms for data collection eliminated geographical limitations, with the potential to undertake interviews almost anywhere in the world.

The Microsoft Teams transcription function was used to transcribe the interviews. It is, however, not perfect, and its effectiveness in producing a reliable and accurate audio record of an interview, depends on the clarity, enunciation and accents of the interviewer and interviewee, as the transcription function tends to misinterpret words it doesn't understand. For example, the line '*No, I'm originally, I'm Glaswegian*", was transcribed by Teams as '*No, I'm*

Additionally I glass region'. Because of this flaw, each interview was recorded separately, using an independent audio recording application. The transcribed Teams interviews were then downloaded as Microsoft Word documents and carefully cleaned by the Chief Investigator, while listening to the audio recording of the interview, to produce verbatim transcripts (*Appendices 4.2.1.1 to 4.2.2.9*[3]). Video recordings of the interviews were not undertaken.

4.2.5 Analysis

IPA is a relatively new and evolving qualitative method. The analysis followed the most recent guidelines recommended by Smith and Nizza (2022), which are modifications to Smith et al.'s (2009) original IPA guidelines. However, the latest, much shorter version (Smith, & Nizza, 2022) and the more comprehensive original text (Smith et al., 2009) are complementary. The newer version (Smith, & Nizza, 2022) was the primary source of guidance for analysis, while the earlier, original book (Smith et al., 2009) was a constant and extremely useful point of reference, both practically, and from a theoretical perspective. The modifications in the newer version, apply to a few of the main terms used in describing the process of analysis. The new, modified terms have a greater emphasis on experience, in line with IPA's primary theoretical aim of exploring the personal lived experience of the interviewees. For example, *emerging themes* has been replaced with *experiential statements*; *individual superordinate themes* are now *personal experiential themes*. Both texts emphasise the flexibility of IPA, pointing out that IPA guidelines are fluid, and that researchers should feel confident about adapting them to suit the aims of their research questions. That said, using the modified terms, the analysis in the current research adhered to the steps common to both versions.

Before analysing the texts, the clean transcripts were digitally changed to a three-column landscape format. For this purpose, desktop publishing (DTP) software was used (QuarkXpress). Similar DTP software can be employed, and the change of format can even be undertaken using Word, although for ease of use and marking up text, DTP software is

preferable; digital software was used for these practical purposes only, and not for analysing data. Experiential statements were written in the left-hand column, the middle column contained the transcript, with line numbers, explanatory notes were recorded in the third (right-hand) column. IPA is a time-consuming and iterative method. The first step involved reading the transcript at least twice, to become familiar with the narrative data. It is during this phase that the interpretative process involving a *double hermeneutic* emerges, i.e., the researcher becoming immersed in the text and attempting to make sense of the participants' attempting to make sense of their discourses.

Interpreting experiential statements

Firstly, exploratory notes were taken, these not only informed the interpretation, but were useful later on, in informing the results and discussion sections. Next, using different coloured highlights, informative and revealing statements/quotes were identified and highlighted in the participant's narrative (centre column). These were interpreted into experiential statements, which were then reported in the left-hand column, along with the line and page number/s. It is normal for the same experiential statement to appear multiple times throughout the transcript; the line and page number/s of subsequent instances of the same experiential statement, appear alongside the first instance of the statement. For ease of use, experiential statements associated with the active drinking voice were highlighted in red. The experiential statements associated with the recovery voice (in the next chapter) were reported in green. Because the interview schedule was a linear design, i.e., drinking story followed by recovery journey, the recovery voice, typically appeared later in the transcripts. The first two steps were repeated for each page. The interpretative process is a fluid and evolving one, and meant, at times, that the wording and subsequent meaning of experiential statements were changed, as each page of transcription was explored. Refer to *Appendices 4.3.EO.1 to 4.3.EO.9* and *4.3.LO.1 to 4.3.LO.9*

for a better understanding of the analytical process[4]. The next step involved clustering the participants' experiential statements into personal experiential themes.

Clustering experiential statements into personal experiential themes

The clustering phase followed the method described by Smith and Nizza (2022). Firstly, lists of pre-recovery and recovery experiential statements were compiled and printed. The individual statements on the list were cut out, so that each was on a separate piece of paper. The statements were then placed randomly on a table, giving a "bird's-eye view" (Smith, & Nizza, 2022, p. 43). Statements were then moved around until clusters of experiential statements with "conceptual similarities" (Shinebourne, & Smith, 2009, p. 155) began to form. *Appendix 4.4.* describes the method of experiential statements being clustered into personal experiential statements. In common with the earlier interpretative process that occurred during the ESs stage, the clustering phase is fluid, meaning that statements were moved between groups until the researcher was satisfied with the clustering/grouping. Each cluster of experiential statements was given a title (personal experiential theme) that was conceptually representative of the experiential statements contained within it. Again, this process was not static and after periods of reflection, titles of personal experiential themes were changed. This method was repeated for each individual case. During the process, when it became apparent from a conceptual perspective, that individual experiential statements could not be assigned conceptually to a personal experiential theme, they were discarded. Adhering to the iterative IPA method, during the clustering stage of analysis, the participant's transcript was an important and constant point of reference, helping the researcher to maintain a connection with the participant's unique and personal discourse.

Following the clustering phase of analysis, tables of each of the individual participants' personal experiential themes and experiential statements were compiled (*Appendices 4.5.EO.1 to 4.5.EO.9 & Appendices 4.5.LO.1 to 4.5.LO.9*). The tables comprised experiential statements,

along with the line and page numbers that had been identified during the first stage of analysis, but in a much more structured, and easy-to-read format. Each table had the participant's name and their personal experiential themes conceptual title at the top, with the table directly below. For ease of use and visual identification, the themes were each assigned different colours. The table had three columns. The first column had the personal experiential themes conceptual title at the top followed by the corresponding experiential statements. The corresponding line and page number/s were situated in the second (middle) column. The third column contained the quotes (or a portion of the quote) which related to the experiential statement in the first column. Again, for ease of use, each block of personal experiential themes along with their corresponding experiential statement, were coloured in a shade of the personal experiential theme that it represented.

Bringing it all together — moving from personal experiential themes to group themes

The final stage of analysis for both cohorts involved finding comparisons and links between the personal experiential themes of the individual participants (*Appendices 4.6 & 4.7*) and clustering the personal experiential themes into *group experiential themes*, that made sense conceptually. The group experiential themes (Figure 4.1), along with extracts from the participants' personal experiential themes inform the narrative account in the results section.

A note on tables

In IPA, a table is "the outcome of an iterative process in which" the researcher "has moved back and forth between the various analytic stages ensuring that the integrity of what the participant said has been preserved as far as possible. If the research has been successful, then it should be possible for someone else to track the analytic journey from the raw data through to the end of the table" (Eatough and Smith, 2006, p. 487)[5].

4.3 RESULTS

4.3.1 Demographics

Tables 4.1 and 4.2 provide a summary of the participants' demographics. A.A. was reported by six participants as being the organisation where their recovery began (three from each cohort). Two participants reported a combination of the NHS and Smart Recovery (one early- and one late-onset), while one participant reported Smart Recovery alone. The remaining nine participants each reported a different organisation as the starting point of their recoveries. Six of the early-onset participants reported their drinking becoming problematic before the age of 30, one between 30-35 and two between 35-40. Regarding the late-onset participants, six reported their drinking became problematic between 45-50, two between 50-55, and one between 55-60. The mean age of the two cohorts was similar; the early-onset cohort ranged from 50-years-old to 71-years-old (*m* = 60-years-old); the late-onset participants ranged from 53-years-old to 67-years-old (*m* = 61.7-years-old).

There was, however, a considerable difference in recovery years between the two cohorts. The length of time in recovery for the early-onset participants ranged from 18-months to 35-years (*m* = 12.27-years), almost three times as long as the late-onset participants, whose time in recovery, ranged from one to 15 years (*m* = 4.6-years). The difference in length of time in recovery between the two cohorts is not surprising, as the early-onset cohort, simply stopped drinking and came into recovery much earlier than the late-onset group. One participant had a religious belief system, two believed in a concept of God, but not in a religious context. Seven participants reported having a spiritual belief system. The remaining eight participants, four from each cohort, reported their ontological position within a secular framework. All participants were Caucasian. Most of the participants had a high socioeconomic status (e.g., G.P., microbiologist, journalist, musician). Seven participants reported being retired. 12 were either married or cohabiting and six were divorced or separated. Tables 4.1 and 4.2 on the

following page list seven important demographic characteristics associated with both cohorts, i.e., *age*; *age when drinking became a problem*; *years in recovery*; *recovery organisation*; *belief system*; *employment status* and *relationship status*.

Table 4.1. *Demographics of early-onset participants.*

	Age	Age when Drinking Became a Problem	Years in Recovery	Recovery Organisation	Belief System	Employment Status	Relationship Status
Andy	63	Before 30	10	NHS/SMART Recovery	Secular	Retail Assistant	M/CH
Heather	51	Before 30	1.5	Soberful Life	Secular	Office Manager	M/CH
Jackie	71	Before 30	35	Alcoholics Anonymous	Spiritual	Retired Teacher and Union Representative	M/CH
James	70	30-35	5	SMART Recovery	Secular	Retired Lawyer	D/S
Liz	50	35-40	2.5	Sobalicious	Secular	IT Project Manager/Consultant	M/CH
Michael	64	Before 30	13	Kingston Community Drug & Alcohol Team	Spiritual	Retired Construction Worker	D/S
Mike	55	Before 30	29	Alcoholics Anonymous	Spiritual	Artist	M/CH
Nora	50	35-40	4.5	CGL	Religious	Buyer	D/S
Sheila	66	Before 30	10	Alcoholics Anonymous	Belief in a concept of God but not religious	Retired?	M/CH

Table 4.2. *Demographics of late-onset participants.*

	Age	Age when Drinking Became a Problem	Years in Recovery	Recovery Organisation	Belief System	Employment Status	Relationship Status
Audrey	63	45-50	2	Turning Point	Secular	Retired Banker	M/CH
Claire	66	50-55	7	Local Authority (Acorn)	Secular	Retired Social Worker	M/CH
Geoff	54	45-50	3	Try Dry (Alcohol Change UK)	Spiritual	Computer Programmer	M/CH
Jack	67	45-50	15	Community Addiction Team Glasgow	Secular	Retired Journalist	D/S
Kate	60	45-50	2	One Year No Beer	Secular	Retired Engineer	M/CH
Kerry	53	45-50	3	Alcoholics Anonymous	Spiritual	Microbiologist	M/CH
Sarah	64	45-50	1	Alcoholics Anonymous	Spiritual	Retired GP	D/S
Steffen	62	55-60	2	NHS online/Smart Recovery	Spiritual	Software Engineer	D/S
Terry	67	50-55	7	Alcoholics Anonymous	Belief in a concept of God but not religious	Professional Musician	M/CH

Key to abbreviations: CGL = Change Grow Live; M/CH = Married/cohabiting; D/S = Divorced Separated

4.3.2 Summary of the narrative account of group experiential themes

The focus of the results section is to present and commentate on extracts from the group experiential themes of both groups of problematic drinkers, in the context of their retrospective active drinking voices. Extracts from the personal experiential themes of individual participants are used throughout. In total, there were four group experiential themes for the early-onset

cohort and three for the late-onset group (Figure 4.1). In line with the method described by Smith and Nizza, (2022), some of the group experiential themes have been divided into sub-themes to make them more manageable (i.e., early-onset group experiential themes 3a and 3b, and late-onset group experiential themes 3a and 3b). The presentation of each group experiential theme is preceded by a diagram (Figures 4.2 through 4.10). Each diagram shows the individual participants' personal experiential themes†, that constitute each group experiential theme. Also refer to the tables in *Appendices 4.8 & 4.9*.

†One of the personal experiential themes of late-onset participant Steffen (*Major life events 1: A combination of major life events*) maps onto three of the late-onset themes/sub-themes (1, 2 & 3a).

Figure 4.1. *Group Experiential Themes.*

4.3.3 EARLY-ONSET GROUP EXPERIENTIAL THEMES

4.3.3.1 Early-onset theme 1

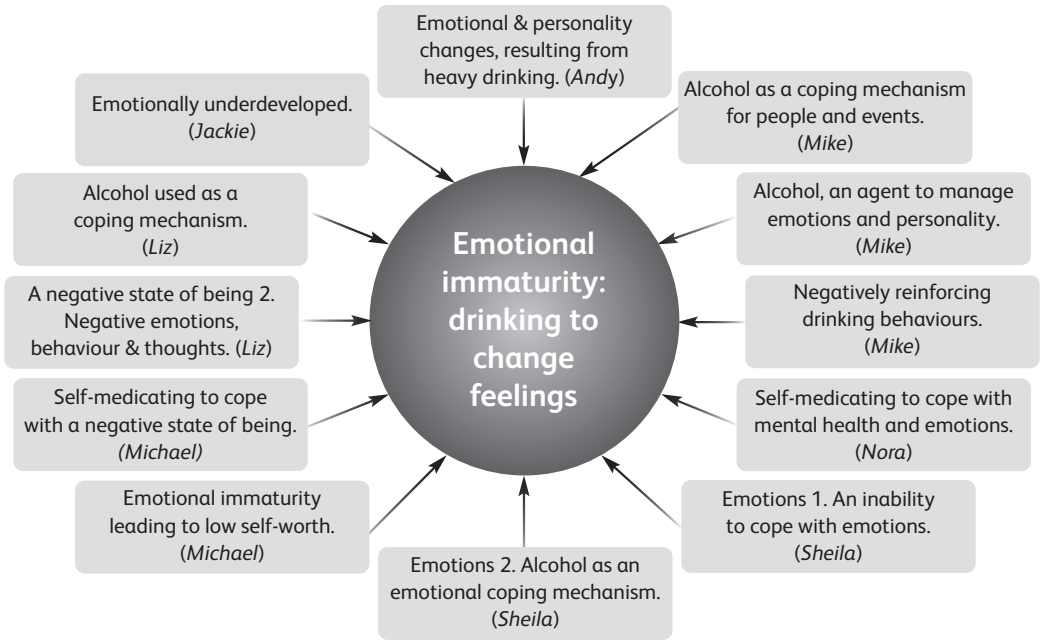


Figure 4.2. *Early-onset group experiential theme 1 and constituent personal experiential themes.*

The discourses of six of the early-onset participants revealed signs of a stagnation in their emotional development. To cope with their under-developed emotions/feelings, they self-medicated with alcohol. Andy, for instance, was introduced to alcohol at a young age, with his school friends. His drinking was problematic from the beginning and became so much more than the 'rights-of-passage' type of drinking, enjoyed by his school friends; Andy drank to change the way he was feeling.

> *Back then, I was doing it to overcome shyness and lack of self-confidence. Ehm, because my close friends from school, I was still at school then, I was fine and extrovert and outgoing, but inside I, I, I felt that I was playing a part. So, ehm, I found that the alcohol dispensed with the feeling of playing a part and made me feel that I was the life and soul of the party…* (**Andy**)

Similarly, Mike talks about the agency that alcohol had to change his emotions and feelings. Mike, powerfully, described having a complete personality change when he drank excessively, comparing his own alcohol-induced transformation with the dual personalities of Dr Jekyll and

Mr Hyde. In common with the good Dr Jekyl, who was aware of the chaos that ensued when he drank his potion and transformed into the sociopathic Mr Hyde, Mike too, was aware of the chaotic consequences of his drinking, nonetheless, he still drank.

> *So, I became the classic Doctor Jekyll, Mr Hyde story which all alcoholics identify with. So, I was a responsible, caring individual. Put the drink in me, I'll become an irresponsible, uncaring individual, selfish more selfish. So, the demons were allowed out of the bag when I drank…*
>
> *It was, you know, I chose to do it, and I was in control of it. But in the same way, Doctor Jekyll picks that bottle up and drinks it. He knows what it's going to do to him, but chooses to pick it up and drink it, and that's why it's such a powerful story for me, because he knows. He knows all that stuff is already there, it's already in him.* (**Mike**)

Jackie's problematic use of alcohol was a symptom of a deeper, underlying inability to cope with her stunted emotions and low self-esteem. Jackie, for example, had also used men and marriage to fulfil the same emotional function as alcohol, i.e., to change the way she was feeling; albeit, for short periods of time, similarly to alcohol.

> *So, emotionally, I think there was a lot of remorse, you know, ending up in situations which I felt really ashamed about. So, I think adding to my low self-esteem, which I had and my low self-confidence which had never been kind of very strong.*
>
> *I had this kind of series of marriages. I mean, I was married at eighteen. And I then split up, uh, or left my husband when I was about twenty-one, I think twenty-one, twenty-two. And then this guy I got married to in Canada when I was sort of twenty-two and that that lasted nine months or so. And then number three was… actually… when I was sober.* (**Jackie**)

In common with many people, Michael drank, in part, to relieve social anxiety. Alcohol enabled him to behave in a gregarious, uninhibited way, that was not possible when he was

sober. Michael's social anxiety was accompanied by a multitude of negative emotions, including an ever-present feeling of fear. Michael talks about being *"feared up as a kid"*. So when he came across alcohol at a young age and it removed the fear, he believed he had found the answer that allowed him to behave like other children, free from fear. After all, in childhood, it is only natural to want to fit in and be like the other children. Alcohol was the solution to Michael's emotional conundrum. The solution, however, eventually led to feelings of shame, which in turn generated low self-worth.

> *I could do things, that I would probably be feared up to do, if I wasn't, if I didn't have a drink inside me, you know. I could talk to people, I could talk to anyone in the pub with a drink, but without a drink, I would have been in the corner minding my own business, too frightened to say anything. It's a fear, fear-based, I believe it's a fear-based illness. For myself 'cos I was, I was feared-up as a kid. I had nothing to be feared-up about, I had a good upbringing, I had lovely parents, I've got a lovely brother, but I always felt as if I was on the outside looking in, I didn't feel part of. I realise I never felt a part of anything.*
>
> *You took that drink out of me, I was, I was a frightened little lamb, you know. I couldn't face anyone and at the end of the drinking, I don't think I, I don't think I ever saw a tree because I was always looking down on the floor because I was always ashamed of myself, the way I'd become.* **(Michael)**

Conclusion to Early-onset Theme 1

Most of the participants in the early-onset cohort found it difficult to regulate their emotions. Challenged by a plethora of negative feelings and emotions (e.g., fear), anxiety and low self-esteem, they found, very early in life that alcohol removed anxiety and fear and, simply changed the way they felt.

4.3.3.2 Early-onset theme 2

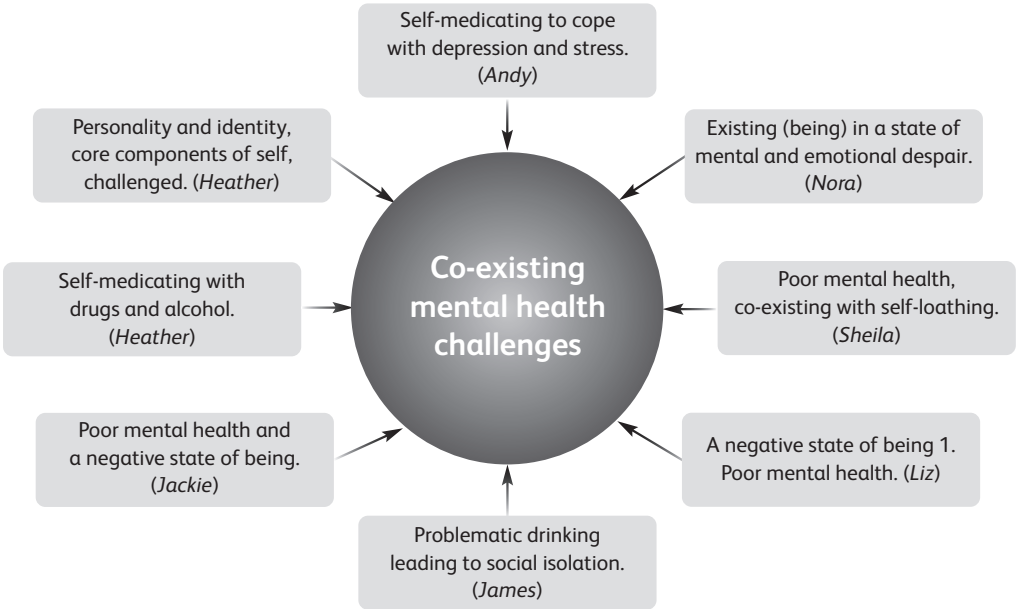


Figure 4.3. *Early-onset group experiential theme 2 and constituent personal experiential themes..*

According to the literature review, undertaken earlier in the thesis, early-onset drinkers are more likely to suffer from depression and anxiety (see chapter two, 2.4.3; also see Schonfeld et al., 1987; Schonfeld & Dupree, 1991). In common with those findings, seven of the nine participants in the early-onset cohort reported experiencing co-occurring mental health challenges. That said, co-occurring mental health issues were equally present in the late-onset cohort (see Table 4.4). In common with Michael, Heather started using alcohol to manage her emotional immaturity and social anxiety, when she was young.

> *I think a lot of it was social anxiety, ehm ... and also you don't really know this until you've stopped drinking, because ... I mean, I feel like I haven't really matured as an adult because my coping mechanisms was, was, was drinking from a very young age.*
>
> **(Heather)**

Heather also used alcohol to cope with more than her social anxiety and immature emotions. Clinically diagnosed with depression and anxiety, Heather self-medicated and 'quietened' her intrusive and negative mental activity, using a cocktail of alcohol and prescription drugs.

> *So, in the back of my mind, I've always had …. worried about… I've suffered about three terrible bouts of depression, emh, also one that led me to quite bad suicidal thoughts, again, all the way through this, even though I'm taking medication apart from after I'd had Zoe because I was like, zombified, I would drink along with my medication because it, it turned my brain off. So, a lot of my drinking, I would say, did start off from self-medicating, to try and turn off my brain, to do with depression or psychosis or, or what have you.* (**Heather**)

The term 'self-medicate' is a linguistic thread, used throughout the participants' narratives. Nora also used alcohol as a method of self-medicating the mental anguish she had experienced while trying, unsuccessfully, to conceive.

> *And, ehm, then I had a rough time because I had, I had an ectopic pregnancy, and I also had, ehm, a cyst at the same time, which ended up me having two operations and then not being able to conceive another child.*
>
> *Yeah, so, that happened, and I did start to self-medicate, you know, I started to feel very depressed, ehm, 'why me?' Ehm, had time off work to recover from the operation. Ehm, but then my drinking really took off around that time.* (**Nora**)

Sheila had a multitude of mental health and neurological issues, including obsessive compulsive disorder (OCD), anxiety and paranoia. In truth, like many people who experience mental health and neurological disorders, Sheila's OCD, anxiety and paranoia were mutually supportive (Sheila still has OCD but finds that it is easier to manage in recovery).

> *Ehm, I didn't 'wanna go out the house, so it made, it made my OCD even worse, as well. Yeah, the paranoia was awful.*
>
> *Very, very anxious, very low mood, very jittery. My, my physical, my physical well-being was very, very jittery…. I went to private, private counselling, ehm, way before joining A.A., and I've also had private counselling since […] it's, it's less than, now. When I was drinking, it was, it was, it was on me the whole time.* (**Sheila**)

Conclusion to EO Theme 2

The theme is confirmation of what is already known about the high prevalence of co-occurring mental health problems in individuals who experience AUD/problematic drinking, with depression and social anxiety disorder being the most prevalent condition among the group. Very early in life, in common with the first theme, the early-onset cohort found that they could self-medicate their poor mental health using alcohol.

4.3.3.3 Early-onset theme 3a

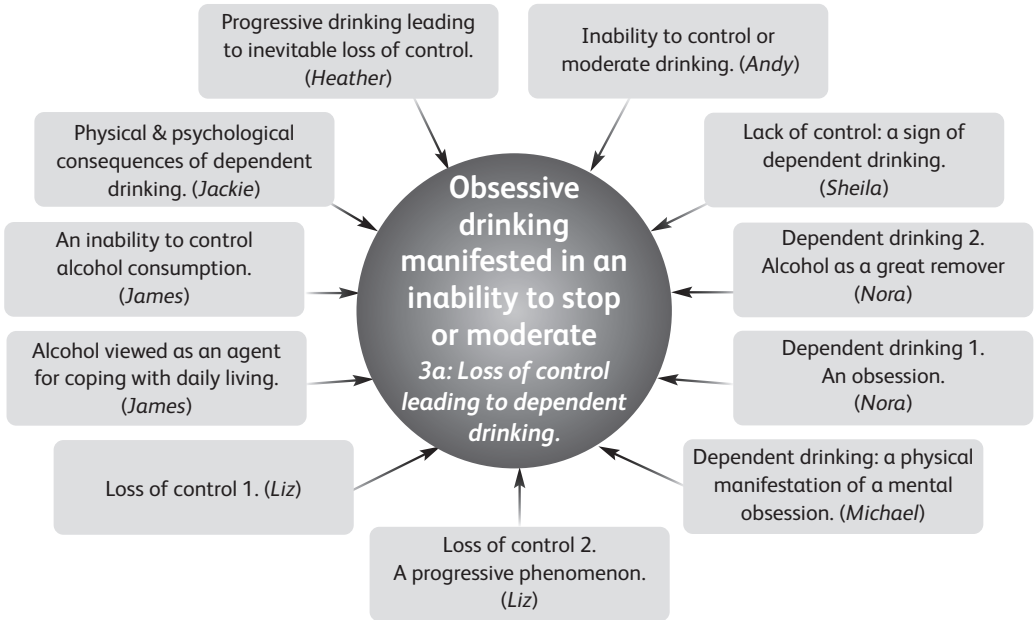


Figure 4.4. *Early-onset group experiential theme 3a and constituent personal experiential themes.*

The third early-onset group experiential theme is divided into two sub-themes. A prominent characteristic of the early-onset cohort during analysis was an all-consuming obsession with alcohol (in varying degrees). James describes his attempts to cut down, unfortunately, his obsession and his loss of control was far more powerful than any motivation he may have had to stop drinking.

> *I was trying to taper off and I was quite convinced that tapering was the rational way to do it. And I couldn't, I got to a point and I just couldn't bring it down. I think it was about seventeen to twenty units a day. You know from forty* to twenty's not bad, that*

> *was my core, and I stuck there for about a week or ten days and just could not shift it and felt that it was actually going to go into reverse.* (**James**)

*Forty units of alcohol is approximately a litre bottle of spirits, e.g., vodka.

In early-onset drinkers, the obsession, commonly referred to as a craving, can manifest after varying periods of sobriety, often prompted by an irrational plan. Nora, for example, decided after a period of sobriety, that drinking only at weekends seemed like a good plan.

> *'I, I'm going to drink, you know, just at weekends, I'm 'gonna drink safely and I'm 'gonna have alcohol-free days. I'm gonna do all this, and I'm not 'gonna go back to it, how I was before. But it didn't take very long for me to go back to old habits. Ehm, so, as soon as I picked up that first drink, I was wanting my second, and me third and me fourth. And, you know, I slowly then started to drink secretly, because, you know, here's me, I've been through recovery, you know, I've been for a detox, and I've started drinking again and then it all went downhill from there. So, the shame, the guilt, the remorse was all over me again.* (**Nora**)

Conclusion to Early-onset Theme 3a

The loss of control and obsessive alcohol cravings that are typically associated with alcohol dependence that emerged in the discourses of all the early-onset cohort (except for Mike) are, in part, the consequence of the emotional and mental challenges that were so clearly apparent in the first two themes.

4.3.3.4 Early-onset theme 3b

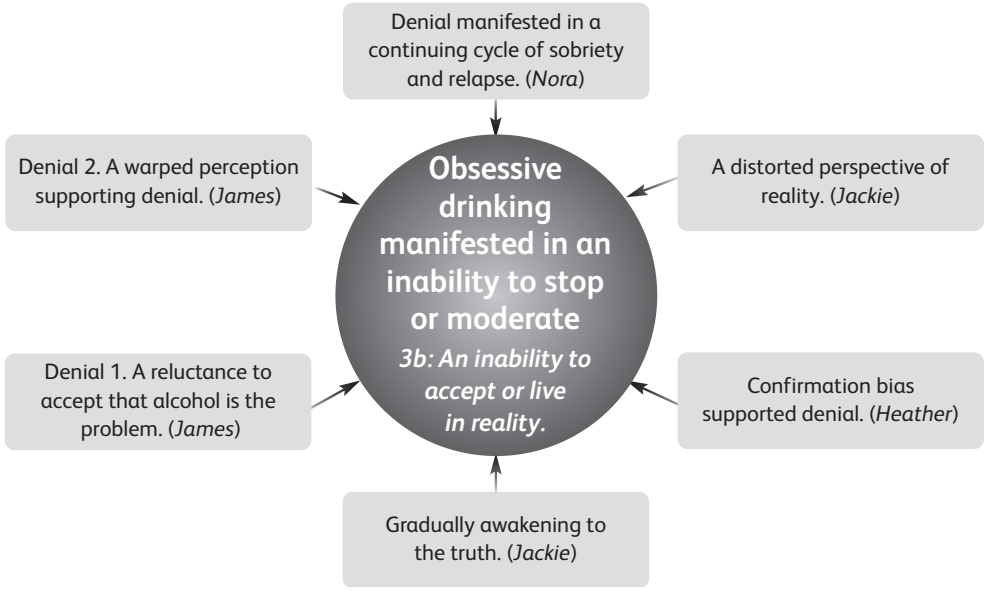


Figure 4.5. *Early-onset group experiential theme 3b and constituent personal experiential themes*

Heather normalised her drinking, thereby reinforcing her denial by comparing her drinking to a constructed version of a typical *"alcoholic"*, convincing herself, and others, that her drinking did not fit into the same category. Heather's version of a problem drinker was an individual who drank every day, especially in the morning, i.e., *"vodka on your cornflakes"*. While James' denial came in the form of a reluctance to accept that alcohol was the problem, even though, at the time, he was about to enter a treatment centre.

> *But we, we made rules up to say we're not alcoholics, I don't drink on a Monday, and I don't drink on Thursday, and if I was an alcoholic, I would drink every day of the week, wouldn't I? … And, and if you're not having vodka on your cornflakes then you can't be an alcoholic…* **(Heather)**

> *I kept saying to myself, I'm just going through a bad patch now, once I get my itself back on my feet, I will be fine. Not realising, of course, how deep rooted and multi-faceted addictive behaviour is. So, I booked for one week, and at the end of that week, I booked myself in for a second week. And at the end of the second week, rather than going home, I booked myself in for a third week. By the end of that, I thought I'd done*

> *as much work that was necessary to better understand my situation, and that was in 2017.* (**James**)

> *I remember a woman at work saying to me, Janet, you're really lovely and you know, you've got a lot going for you, but you really don't need to drink as much. And I remember thinking, what a bloody stupid thing to say. You know how? What a ridiculous, non-sensical …. So, at that point I just had no idea. The denial was so massive, I just wasn't going to hear it.* (**Jackie**)

Conclusion to Early-onset Theme 3b

This second sub-theme described the difficulty that some members of the cohort faced in accepting a shared reality, instead creating their own version of reality, reinforced by denial. The final extract by Jackie illustrates how the perception of the early-onset problem drinker and that of the person observing them, are two, completely different constructs, whereby the denial of the early-onset problem drinker, automatically filters out the reality constructed by the observer. The two sub-themes that constitute the third theme show that the use of alcohol to cope with negative emotions and poor mental health, eventually stopped working, and that the early-onset cohort's inability to stop or moderate their drinking, was confirmation of alcohol dependency.

4.3.3.5 Early-onset theme 4

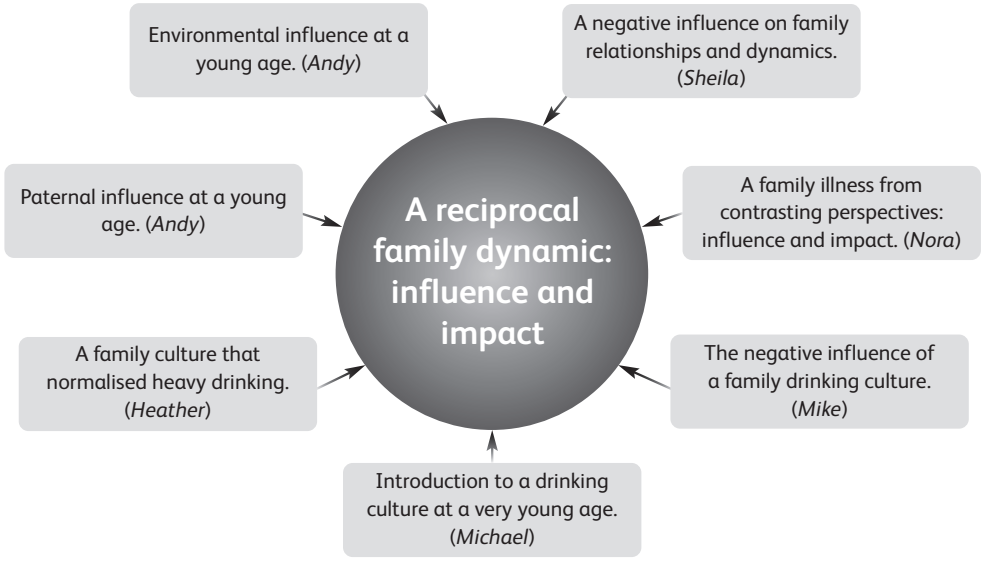


Figure 4.6. *Early-onset group experiential theme 4 and constituent personal experiential themes.*

The influence and impact on the family featured in the accounts of six of the participants. The relationship between the participants and their families in the context of alcohol, was a dynamic one. That is, their drinking was not only influenced by growing up in a family environment where alcohol was normalised, but their drinking behaviour also had a negative impact on their friends and families. In Mike and Heather's narratives, a drinking culture was not only accepted, it was even encouraged.

> *I had an alcoholic family …. My grandmother and my grandfather drank continuously non-stop, and I, when I say a lot, they drank a lot. My whole family was riddled with people who drank. My nan used to get a bottle of brandy and three bottles of whiskey every week, and she used to pour it in her tea, pour it in the teapot. You know, it was just everywhere. It was awash, awash with it.*
>
> *So, it was not strange I was drinking as a child. They would give me drink because that's what we all did. And they thought it was well, you might as well be drinking now because you're going to be drinking later. So, you know, they used to put it in my bottle when I was a baby.* (**Mike**)

> *I used to go and drink wine in the precinct with my friend, my dad made homemade wine … Ehm, and going back to my dad, even when I first passed my driving test and I was eighteen, my dad actually taught me to drive and as a present, he bought me a bottle of vodka. I mean, who would do that for a daughter who's eighteen years old, buy her a bottle of vodka to say congratulations for passing your driving test?*
>
> (**Heather**)

The negative, emotional impact that Nora's 'out of control' drinking had on her family relationships was evident. The shame, remorse and guilt she was feeling was further magnified by her family openly questioning her drinking behaviour.

> *So, the family was starting to say, you know, take it easy today, you know. Ehm, my husband had said, "just take your time when you're drinking"… Ehm, family started to notice, you know, get togethers, I'd, I'd be drinking. Ehm, I ruined my ex-husband's mum's birthday because I turned up drunk.*
>
> *…my ex-husband was saying to me — even though he was a big drinker — he was saying to me, you know, "you're drinking too much".*
>
> *Ehm, I got found on a roundabout, on the middle of a roundabout, smashed all my face in, ended up in hospital, through drink. Ehm, I had my brother crying. You know, asking me to stop.* (**Nora**)

Sheila's drinking, similarly, affected her family relationships in a negative way. She believed that her drinking behaviour was the cause of her marriage breaking down, as well as damaging her relationship with her son, which, after ten years in recovery, remains strained.

> *It killed my marriage [….] I used to be very, very nasty. I could turn with the drink, I could turn very, very nasty. And I did lots of pointing and bad language, "It's you, you cunt, you make me drink", you know?*

> *It did a lot of damage to my son. My relationship with my son is, it's not good. On a daily basis, I try and make it best today. He won't let me make amends to him, he just walks away [….] Ehm, at one time I said to him, "look, you know what, what've I done that's so wrong?" He said, "well, you know what you've done". To this day, I don't know what he means, and my ex doesn't know what he means [….] I'm not proud of my relationship with my son.* (**Sheila**)

Conclusion to Early-onset Theme 4

Theme four highlighted the influence and impact that family drinking cultures can have on early-onset problem drinkers, and the dynamic reciprocal impact the problem drinker can have on the family. Importantly, it further highlights that problematic drinking is far-reaching and that the problems associated with problematic drinking are not restricted to the problematic drinker, and that they are not necessarily resolved when the problematic drinker finds sobriety.

4.3.4 LATE-ONSET GROUP EXPERIENTIAL THEMES

4.3.4.1 Late-onset theme 1

Figure 4.7. *Late-onset group experiential theme 1 and constituent personal experiential themes.*

The first late-onset theme is common to eight of the late-onset participants. Two strands run through the theme. Firstly, the participants' narratives suggest that the transformation in their drinking behaviour was not a sudden event. The second strand highlights that the transition from social drinking to problematic drinking was like crossing an invisible line. The baseline for the participants' alcohol consumption, before it became a problem, can be described as social drinking, whether it was occasional alcohol consumption or drinking above the recommended guidelines. Kerry's extracts highlight both, her status as a typical social drinker and her gradual progression towards crossing the invisible line to problematic drinking.

> *I think I always was a drinker; do you know what I mean? I, I was a social drinker and I suppose it was just like, I looked around at my peers and it was, yeah, I'll go for a few, for a few drinks on a Friday night and things like that.*
>
> *And then it went to drinks a couple of evenings a week and then it was every night and then it was, you know, every afternoon, and then it was all day.* (**Kerry**)

Like Kerry, much of Gary's journey from social drinker to problem drinker, was situated in a professional, working environment. Gary's discourse is littered with anecdotes, typically associated with social drinking. His narrative also describes the gradual progression towards dependent, problem drinking.

> *I used to go out for a lunchtime drink, you know. So, you know, I'd make it to lunch time, have a nice lunchtime drink, you know, feel a bit merry and then go back to work in the afternoon, you know, so that would be another sort of habit that I'd had, you know….*
>
> *I got to the point where being asked to do something at work that I didn't really feel like doing, you know, there's some fairly, really boring things that were mandatory at work. I don't know, almost as a sort of passive-aggressive thing, I'd think, 'well, I'll have a whiskey from the cupboard and then I'll do this bit of boring work….* (**Gary**)

Claire's narrative too, is similar to Kerry's, however, whereas Kerry admitted to "*always being a drinker*", Claire went further, by declaring that she was "*always a heavy drinker*". When Claire described the progression of her drinking from heavy social drinker to problematic drinking, she was reluctant to describe it as dependent, framing it rather as a *"habit"*.

> *I was always a heavy drinker, yeah (?) but it wasn't so much out of my control. I think it become much more habitual, and so for me…. For me, it led to the habit. Big habit, it was getting more and more and more, and it was hard to get out of the habit of not having a drink. Ehm … in spite of it causing me difficulties. Ehm, and I did all the*

> *usual things that people do, you know, try to stop, try to reduce, have a little go at stopping, and picked up again with a couple of hospital spells.* (**Claire**)

In contrast to Claire, Audrey had not been a heavy drinker. She admitted drinking every day "*but not to excess*"; Audrey and her husband would have one or two drinks at home in the evening after work. Audrey's transition from social to problematic drinking began when her husband stopped drinking in the evening, and Audrey realised that she couldn't do the same.

> *I suddenly started secretly having a bottle hidden that I could have a small amount on Monday through Thursday […] a unit or two of vodka would be enough for me at the end of the day, but I needed that unit or two and eventually it wasn't quite enough.*
>
> *…the amounts gradually grew and grew. So, from my late forties 'til about my mid-fifties, I gradually moved from dependence. I developed dependence by my mid-fifties that turned into full blown addiction.* (**Audrey**)

Terry believed his drinking was social, even though as a musician he used alcohol to self-medicate his performance anxiety. Terry recalls the progression of his drinking, however, there is no anecdotal memory of a time when he 'crossed a line' from social to problematic drinking. Indeed, his social drinking *"just vanished"*.

> *I tried to control, umm that uh, self-medication. In the ensuing years, and by and large, I did control it, but of course the level of medication went up.*
>
> *That self-medication gradually, more and more it took over as absolutely the main drinking. They ran side by side the two types, but in the end, the other type, the social drinking, just vanished altogether. It was self-medication and nothing else.*
>
> *I used to have to drink to practice. I would fool myself into doing that by saying, "well, I'm going to be pissed when I actually play, so I might as well practice pissed, so I know what it's like".* (**Terry**)

Jack, another heavy social drinker, for much of his working life, believed that he had control of his drinking, which had become a part of his everyday life. He recalls that his drinking changed later in his career when he began to use alcohol to cope after his contract as a freelance journalist was not renewed. This may have been the point when Jack crossed an 'invisible line'.

> *… for most of my working life in journalism and in public relations, alcohol was there, but I feel it was controlled. Ehm, you know, I used my car for a lot of my PR working and a lot of journalism, so, I was careful in what I was drinking.*
>
> *… alcohol was probably just a normal part of my life but always on a controlled basis, it was only when the thing about, the lack of security that came from the contract not being renewed that I began to use alcohol as a crutch to get me through, that kind of day-to-day basis […] I got used to year-long contracts, one was not given to me, and I went back to working there on a day-to-day basis at the BBC and then it began a case of coming home at night and having drinks to sort of get through the day…*
>
> *I was getting through the day of working the extra shifts or whatever and coming home and my first port of call was the whiskey, in the cabinet, which became, eventually over a course of about five years, a bottle of whiskey per night, until ….* (**Jack**)

Conclusion to Late-onset Theme 1

As indicated by the theme's title, the late-onset group's descent into problem drinking was a gradual process, even though a few members of the cohort were heavy social drinkers. That said, although the change in drinking behaviour was gradual, most of the group experienced an event, or series of events, that acted as a catalyst for a considerable increase in alcohol consumption, which in most instances were associated with a change of job role, or loss of job, and a subsequent impact on their professional identity. In contrast, the problematic relationship the early onset cohort had with alcohol was more sudden, mostly a reaction to a lack of emotional regulation. The early-onset group's drinking could never have been described as

social drinking. The theme highlights one of the major differences between the groups, i.e., the gradual emergence of problematic drinking in the late-onset cohort, which in most instances culminated with a tipping point event, compared to the earlier and seemingly more sudden descent into problematic drinking, of the early-onset group, which was due, in part, to an inability to regulate and manage emotions.

4.3.4.2 Late-onset theme 2

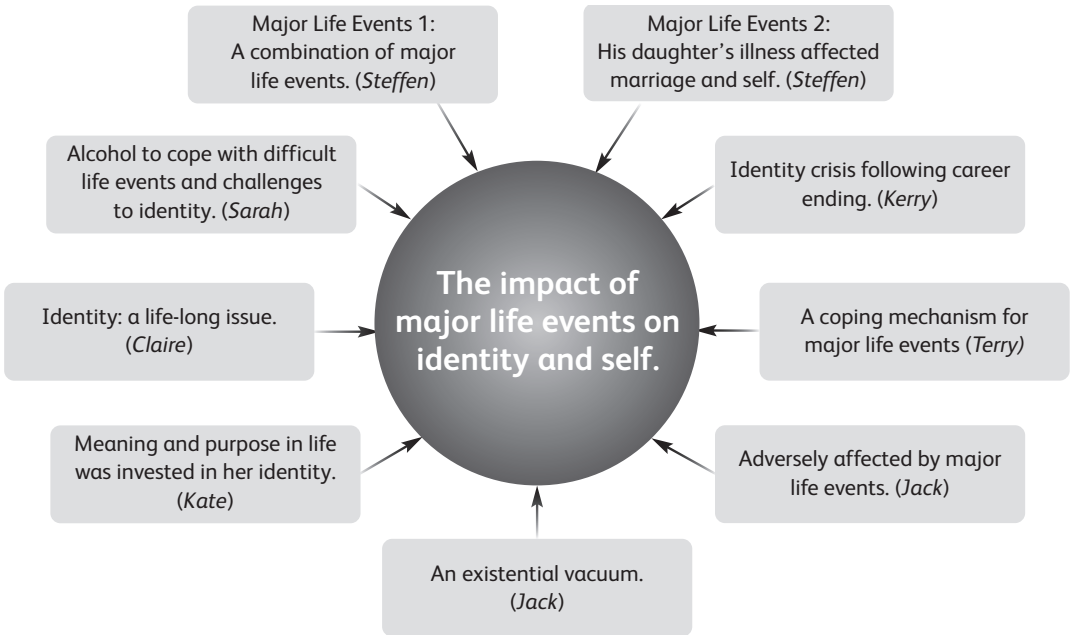


Figure 4.8. *Late-onset group experiential theme 2 and constituent personal experiential themes.*

Major life events impacted considerably on seven of the nine late-onset participants. This theme permeates the other themes, which can be seen in Jack's experience of not having his contract renewed, highlighted in the previous theme. Challenges to their professional identity, as experienced by Jack, affected all seven participants; five of them talked directly about the impact that major changes in their professional working lives had on their identities and consequently their drinking behaviours. For example, Sarah, a high achiever, had been to university and medical school.

> *It wasn't a part of my identity it was my identity (Sarah emphasises this statement). Being a doctor, being a working mother was my identity (again, Sarah emphasises this). I had no idea about this when I first came to A.A., this hole in the soul thing. I had no idea about fear because I've lived my life thinking I was in control of everything and in my household, you weren't frightened of anything.* (**Sarah**)

Having gone into residential treatment for the first time ten years ago, maintaining sobriety has been difficult for Sarah; at the time of the interview, Sarah had been sober for eleven months. She didn't drink for six years after leaving treatment but started drinking again to self-medicate her emotions, after her parents died.

> *I think, I read that it was because I didn't have the emotional capacity to deal with my life events at that stage, that's why I think I relapsed.* (**Sarah**)

Identity had always been an issue for Claire, who grew up in care. When Claire, a social worker, changed from a role that she had been doing for a long time, to a more demanding role, her ego and her identity were challenged. Previously, she had "*operational contact with people*", whereas the new role was purely administrative. There was also a change in the power dynamic. Whereas once she "*had authority to say to people, whether you like it or not, you've 'gotta do it"*; her new role meant that she didn't have the same level of power, instead, she had to work "*at persuading people*".

> *When, you know, when I got to the point, "I need a drink", that was fairly late on. Ehm …. And on top of that, I would say that, coupled with the identity thing, that there's a lot of stuff around that, you know, stuff about, "Is that what I was doing?" Was I doing it to dampen things down or to buck me up or, you know, whatever?* (**Claire**)

Kate's identity was also challenged by changes to her employment status. Due to bullying, Kate resigned from a role she had since leaving school. Her professional role was the core component of her identity. Even though she won an industrial tribunal case on the grounds of

sexual discrimination and harassment, no longer having her professional role, had such a negative impact on her sense of self, she began drinking to "*oblivion*". Kerry, on the other hand, had to give up her job because of her health; more than anything else, losing her professional role affected her identity and her drinking.

> *I, ehm lost my job, and it's a job that I had since I had left school …. It was something that it, it was something that I used as my identity, "I'm a woman engineer", I was rare, and I, you know, I work very hard at it, and ehm …. So, then I was jobless ….*
>
> *I started drinking heavily then and the only word in my brain was oblivion. For years after that was oblivion. That's all I wanted to do just find oblivion because I'd lost my identity.*
>
> *…. but it was my meaning and purpose at that time. Yeah, exactly, yeah, it was my identity.* (**Kate**)
>
> *…. it became a big problem when I was about forty-seven. Yeah, and my epilepsy came back when I was forty and I had to give up work.*
>
> *I didn't go to university 'till I was twenty-three. Ehm, and then I, I kept studying and studying, got two degrees and then did my masters, and it was all, you know, break the glass ceiling all that sort of thing, and then suddenly I couldn't work anymore, and it just robbed my …. I had nothing to do. I probably felt adrift, I had absolutely nothing. I had no concept of myself outside of my job and my work, you know.*
>
> *I had absolutely no idea of who I was. Completely lost sense of who I was.*
>
> *I would be panicking, because I couldn't remember who they thought, who I told them I was. You know, I had absolutely no concept of self, of who I was, what I was.* (**Kerry**)

<u>Conclusion to Late-onset Theme 2</u>

Affecting seven participants, the theme is unique to the late-onset cohort. The participants' narratives suggest that major events, mostly relating to challenges around their work and

professional identity, had a considerable impact to their sense of self, which in turn impacted on the amounts they were drinking. This theme highlights, that in this cohort of problematic drinkers anyway, professional identity made a considerable contribution to a cohesive sense of self; illustrated in Kerry's extract above.

4.3.4.3 Late-onset theme 3a.

Figure 4.9. *Late-onset group experiential theme 3a and constituent personal experiential themes.*

Except for Jack, all the late-onset participants used alcohol to self-medicate co-occurring mental health problems. These challenges emerged mostly in the form of anxiety and depression. Sarah, a GP at the time, and familiar with the symptoms associated with both conditions, self-diagnosed.

> *…. the lifestyle that I was living was making me feel so anxious at the end of the day, that alcohol took my anxiety away ….*
>
> *When I first started drinking heavily back in, leading up to 2012, the other problem that I had which was related to my alcohol consumption was depression, but I didn't have any physical side effects or anything, but I think I had depression here.*
>
> *I thought "I'm depressed". I had all the symptoms I had early morning waking as well, I had all the classic symptoms of depression. I thought I needed to take a couple of*

> *months off work or whatever, and I went and got some anti-depressants. And then my drinking went up because I was at home. And then I went to a psychiatrist, who took some blood tests from me, and that showed that my Gamma GT* (gamma-glutamyl transferase [GGT]) *was significantly raised, but I hadn't yet done permanent damage, And so he blew my cover, basically. And then I went into rehab from there.* (**Sarah**)

> *So, I just got more depressed, and I started drinking during the day and everything because I was home by myself, you know, so I could get away with it. And you know, I would hide the drinking, you know, and gradually it got to the point where, yeah, I was drinking constantly….*
>
> *…. in my marriage we started, ehm, had started drifting apart. You know, we had some issues, so I was …. I didn't really have anything going for me and alcohol became the, you know, I, I became depressed, you know, I would say very depressed, ehm, I just, you know, gradually went from, ehm, you know, drinking on the weekends to also drinking after work in the evening to, ehm, you know, always having a drink.* (**Steffen**)

Audrey believes she is on the autism spectrum. At the time of the interview, she had never received a clinical diagnosis, rather, she self-diagnosed after taking an online test. Audrey's perceived autism may be associated with her extreme social anxiety.

> *I don't have problems making eye contact. But I can definitely tell I've got, I've caught the kind of social …. I won't call it phobia, that's too strong. But alcohol, you know, when I had when my job went from being pure nerd, I was very nerdy. This is so, this is my happy autistic face* (Audrey smiled with a wide grin to emphasise the point).
>
> *So, it just made it easier for me to do the socialising. That didn't mean I needed to drink every day of the week. That was just, but it was. It was again, it was it normalised alcohol for me in a way that it hadn't been normal for me when I was younger. You know, having a drink was a treat before …. now, and it was oddly, it was part of the job.* (**Audrey**)

Conclusion to Late-onset Theme 3a

As a whole, this theme is congruent to the second early-onset theme, once again highlighting the comorbid relationship between poor mental health and problem drinking, regardless of the age of onset. With the exceptions of Jack (late-onset) and Mike (early-onset), all participants in this study reported poor mental health and self-medicating with alcohol.

4.3.4.4 Late-onset theme 3b

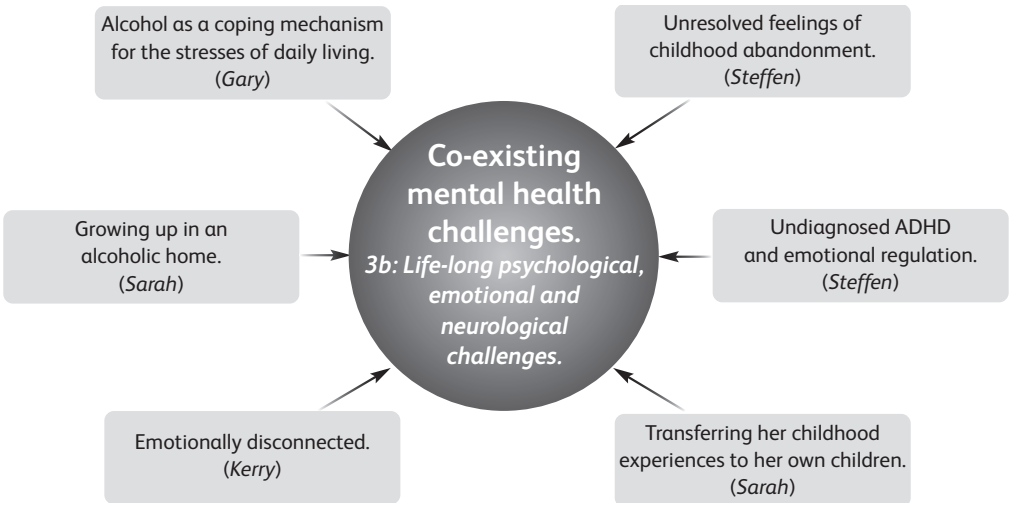


Figure 4.10. *Late-onset group experiential theme 3b and constituent personal experiential themes.*

The last late-onset sub-theme highlights the psychological, emotional and neurological challenges. When he was sixty-two and in early recovery, Steffen was diagnosed with attention deficit hyperactivity disorder (ADHD) and was prescribed the appropriate medication (Adderall). For Steffen, the medication was a "*game changer*". Before his diagnosis, he described his life as, "*like having, I don't know, fifty televisions going, all at the same time, right?*" Importantly, his diagnosis also explained the difficulty he had experienced in his inability to regulate emotions, confirming what he had suspected when he was drinking, that alcohol was a symptom of something more deeply ingrained. Interestingly, Steffen's discourse, once again, picks up the 'emotional' strand that unites all the themes of all the participants, both early- and late-onset.

> *I knew, like, it wasn't just alcohol was the problem, you know? I knew it was more than that.*
>
> *…. my childhood wasn't so great, right? And the problem I had with opiates in my teens was really the first time, the only time I didn't have this, like emotional pain, sort of thing, it was like, definitely self-medicating. And so, for me, the alcohol just eased the tension and the stress and numbed me out, so, it sort of lifted that weight that I was feeling all the time. You know, I could, I could zone out and not have to deal with how I was feeling, so that's, that's really why I drank, I think.* (**Steffen**)

Her epilepsy and poor mental health means that Kerry has experienced acute neurological and psychological challenges for most of her life. For example, she had been diagnosed and hospitalised with anorexia when she was a teenager and has been taking anti-depressants since she was eighteen. Kerry believes that the relationship between addiction and mental health is "*like a co-dependency*".

> *I have probably come to the conclusion myself that, you know, mental health and addiction, there is some link. Either through disposition or the two piggy-back.*
>
> *Yeah, it's clearly like a co-dependency in your head, in my head. Yeah, it's that strange relationship of co-dependency because you can have one without the other, but, you know, once the two get together….*
>
> *I have suffered poor mental health all my life, you know, I'd say from when I was twelve, thirteen.*
>
> *Ehm, emotionally I …. You know, I don't think at the end, I don't think that I really could register emotions. You know, everything was just, ehm, I don't even know …. I, I can't even, I can't even say that I was sad, I think I was numb. I think I was just completely inured to anything.* (**Kerry**)

The experience of caring for his paraplegic daughter, who died when she was just eight years old, had a considerable impact on Gary emotionally. To manage his emotions and the challenges and stresses of daily living, Gary self-medicated with alcohol.

> *I was sort of using the alcohol to sort of cope with a very stressful life.*
>
> *I made excuses to myself that I was drinking because I sort of could cope with my daughter who was severely disabled. She was paraplegic, you know, paralysed from birth. It was a lot of work, we had young twins as well, three kids under the age of two, that's always a tricky thing. It was more of a kind of excuse to myself that I thought, "well, during this difficult time, I'll excuse myself because I can always just, you know, give it up when, when, when things are better, then I'll just be able to stop and that'll be fine".*
>
> *And then I had to sort of get back to sleep to get up for work in the morning, so I'd be, I'd think, "well, I'll have a double whiskey and that'll be fine".* (**Gary**)

Conclusion to Late-onset Theme 3b

The inability to regulate emotions, is evident in this theme, and is congruent with the first early-onset theme, *Emotional immaturity: drinking to change feelings*. However, the noun 'emotion', which appeared in various syntactic forms (i.e., emotion, emotional, emotionally) in eight of the 12 personal experiential themes that constituted the early-onset theme, appeared in only three of the 15 personal experiential themes in the corresponding late-onset theme, suggesting that difficulties with emotional regulation were more prevalent among the early-onset cohort of problematic drinkers than the late-onset group. Moreover, verbatim extracts like, *"I was feared-up as a kid…"* (Michael early-onset), *"I had this kind of series of marriages. I mean, I was married at eighteen…"* (Jackie, early-onset), suggest that an inability to cope with emotions, were more likely to manifest early in the lives of the early-onset cohort than the late-onset group when they were young.

4.3.5 Poor mental health: a shared co-morbidity

This co-morbidity was highlighted in both cohorts, who shared a theme with the same label (*Co-existing mental health challenges*). Lived experience of depression and anxiety was similar across both groups; eight of the nine participants in each group reported experiencing either depression or anxiety, or both. Formal, clinical diagnoses of depression were almost equal across the two groups (four early- and five late-onset). However, only one of the late-onset group received a clinical diagnosis for anxiety compared to five of the early-onset cohort. Three other mental health disorders were clinically diagnosed across both groups; anorexia, bi-polar disorder and obsessive-compulsive disorder (OCD). Additionally, Steffen (late-onset) received a diagnosis of attention deficit hyperactivity disorder (ADHD*) later in life, when he was 62 and in recovery. Moreover, there is known to be a complicated relationship between emotional dysregulation, ADHD and substance use disorders (Zulauf et al., 2014). However, it is questionable whether Steffen's ADHD is associated with his problematic drinking because he had lived with ADHD all his life, and his drinking did not become problematic until his late fifties. Tables 4.3 and 4.4 list the mental health issues reported by the participants, including the clinical diagnoses they have received.

Table 4.3. *Mental health disorders reported by early-onset participants during their active drinking.*

Participant	Disorder	Clinical diagnosis	Disorder	Clinical diagnosis	Disorder	Clinical diagnosis
Andy	Depression	Yes	Anxiety	Yes		
Heather	Depression	Yes	Anxiety	Yes		
Jackie	Depression	Yes	Anxiety	Yes		
James	Depression					
Liz	Depression		Anxiety			
Michael			Anxiety			
Mike						
Nora	Depression	Yes	Anxiety	Yes	Bi-polar	Yes
Sheila			Anxiety	Yes	OCD	Yes

Table 4.4. *Mental health disorders* reported by late-onset participants during their active drinking.*

Participant	Disorder	Clinical diagnosis	Disorder	Clinical diagnosis	Disorder	Clinical diagnosis
Audrey			Anxiety			
Claire	Depression	Yes				
Gary	Depression	Yes	Anxiety			
Jack						
Kate	Depression	Yes	Anxiety			
Kerry	Depression	Yes	Anxiety	Yes	Anorexia	Yes
Sarah	Depression	Yes	Anxiety			
Steffen	Depression		Anxiety		ADHD*	Yes
Terry			Anxiety			

*ADHD is classified as a neurodiverse disorder; it is not a mental health condition.

4.4 DISCUSSION

The study explored the 'active drinking voices' of early- and late-onset problem drinkers, according to the retrospective accounts of the participants, when they were drinking problematically. This section compares and discusses the similarities and differences in the psychosocial characteristics between the two groups. Broadly speaking, the participants' narratives show that regardless of onset type, the consequences of excessive alcohol consumption, inevitability, lead the problem drinker to the same negative, existential destination, e.g., *"I got very drunk and decided I was gonna' throw myself off the balcony, I didn't."* (Jackie, early-onset), *"I had incontinence, I had the great things seeping out of all the bits of my body [….] I may have died…."* (Jack late-onset). A difficulty in negotiating and managing emotional challenges, or perhaps more correctly, "emotional immaturity" (Glatt, 1974, p. 22) was a common thread that permeated the narratives of all the participants, both early- and late-onset.

The relationship between problematic drinking/AUD and deficits in emotion-regulation skills have been recognised for a considerable time and have been well documented (e.g., Bradizza et al., 2018; Dvorak et al., 2014; Petit et al., 2015). The inability to manage emotions, mediates obsessive cravings in problematic drinkers (Khosravani et al., 2017, 2018). Further,

negative emotions such as anger, fear and resentment, are known to be associated with relapse (Berking, et al., 2011; Witkiewitz & Villarroel, 2009). The findings regarding emotional regulation are consistent with a body of work, that has established links between difficulties with emotional regulation (including negative emotional states) and AUD (Jakubczyk et al., 2018; Mason, 2017), alcohol cravings (Suzuki et al., 2020), alcohol dependence (Dvorak et al., 2014) and alcohol-related stress (Sinha, 2022). The participants' discourses once again, highlight the comorbidity of poor mental health and problematic drinking.

The relationship between problematic drinking and poor mental health was reported extensively in the literature review, earlier in the thesis (e.g., Brennan & Moos 1991; Brennan et al, 1993; Dauber et al., 2018; Van den Berg et al., 2014), and similarly, the participants in the current study experienced challenges to their mental health. Recent UK government statistics show that almost two-thirds (64%) of people receiving treatment for problematic alcohol use reported they had a co-occurring mental health need, and alarmingly, 25% of those were not receiving any treatment for their mental health condition (Office for Health Improvement & Disparities [OHID], 2021). Problematic alcohol use and poor mental health are inextricably linked, with the relationship most likely being a bidirectional one, i.e., people who drink problematically, either develop mental health problems or exacerbate existing ones, while people experiencing poor mental health are likely to use alcohol to self-medicate their symptoms (Mental Health Foundation [MHF], 2022).

The relationship between social anxiety disorder and individuals with co-occurring problematic alcohol use is a complex one that has been thoroughly researched (e.g., Buckner et al., 2008, 2013; Thomas et al., 2008). Typically, social anxiety disorder is most likely to emerge between early- and mid-adolescence (Child Mind Institute [CMI], 2023). Of interest, it has been suggested that individuals who experience social anxiety disorder tend to experience greater challenges in recovery because their fear of social interaction is likely to prevent them

from engaging in interventions that include group participation and membership (Book et al., 2009). The disparity between the two cohorts of receiving a clinical diagnosis for anxiety, coupled with the content of their individual narratives, suggests that the early-onset cohort experienced social anxiety disorder and began self-medicating the condition much earlier in life, and to a greater degree, than the late-onset group. Andy, for example, was clinically diagnosed with both depression and social anxiety disorder in his mid-teens and began self-medicating his mental health disorders at the same age. Heather (early-onset) was also diagnosed at an early age with both depression and social anxiety disorder, and used alcohol to self-medicate when she was very young.

In contrast, late-onset participant, Sarah, who also used alcohol as a coping mechanism, did not recall experiencing anxiety in childhood. Rather, Sarah believed that her anxiety was a consequence of her profession (GP), and that self-medicating with alcohol in the evening helped to remove the anxiety that had built-up during the day. Having to use alcohol as a coping mechanism earlier, rather than later in life, emerged as one of the major differences between early- and late-onset drinkers. Another key difference to emerge between the two groups was the control that each group had over alcohol consumption. The discourses of many of the early-onset participants indicates that any control they had over their alcohol consumption was short-lived, quickly replaced by dependency. Dependency was invariably preceded by an inability to moderate, which in turn was accompanied by denial that alcohol was the problem. In contrast, the late-onset cohort's journey towards dependent drinking was gradual. That said, some of the late-onset participants had been heavy drinkers for many years.

At this point, it may be worth considering why some of the late-onset participants, reported being heavy drinkers (i.e., Claire and Terry), but did not report either dependency or problematic drinking until later in life; both reported that their drinking became problematic between 50-55 years-old. However, Terry, a musician, had revealed in his narrative that he

began using alcohol early in his career to manage performance anxiety, and continued self-medicating his condition until he came into recovery. Claire's and Terry's accounts suggest that there may be a sub-category of late-onset drinkers, who have always drunk heavily. Claire and Terry had been in recovery for seven years at the time of their interviews and their memories may have been constructions (Davies, 1997). How different, for instance, would their perceptions of their 'drinking' have been had they been in recovery for a year when they recounted their 'active' drinking? Alternatively, it may simply be that their individual biology and psychology afforded their bodies and minds a greater tolerance to alcohol. Nonetheless, the phenomenon is worthy of further investigation.

The narratives from the fourth and final early-onset theme, *a reciprocal family dynamic: influence and impact*, suggest that compared to their late-onset counterparts, the early-onset cohort, influenced by the family environment they grew up in, were more likely to have developed normalised attitudes towards alcohol and drinking. Some of the late-onset participants also grew up with and were exposed to negative alcohol behaviour. However, the narrative of growing up in a family where alcohol was normalised was far more prevalent in the accounts of the early-onset cohort. This is supported by a body of literature, which has shown that family influences are a risk factor to individuals developing problematic drinking behaviours (Huurre et al., 2010; Marsiglia et al., 2009; Sorocco et al., 2015) as well as other mental health problems (Ellis et al., 1997). Additionally, as the adjective *reciprocal* in the theme's title indicates, the impact was bidirectional, meaning that the participants' problematic drinking also adversely impacted on their families. This was evident in the participants' narratives (e.g., see Nora and Sheila extracts above) and some of the personal experiential theme titles of the individual participants (e.g., *transferring her childhood experiences to her own children*, Sarah).

The penultimate late-onset theme considered *'The impact of major life events on identity and self'*. A considerable body of research in the earlier literature review (e.g., Christie et al., 2013; Emiliussen et al., 2017c; van den Berg et al., 2014; Wadd et al., 2011), shows that negative issues around identity and self-concept, linked to retirement, are the most prevalent risk factor associated with late-onset problem drinking. Similarly, the same challenges to identity, emerged from the participants' discourses, as a major risk factor for the late-onset cohort in the current study. Losing one's professional identity can have a negative impact on one's sense of self (Howie et al., 2004; Teuscher, 2010), and is particularly challenging to professional women (Borrero, & Kruger, 2015; Price, 2000, 2003). It is appropriate that this section concludes discussing the issue of identity. Loss and reconstruction of identity are recognised as opposing pathways that may lead both, to addiction and away from addiction, respectively (Dingle et al., 2015), in other words towards recovery.

4.4.1 Summary of psychosocial characteristics:similarities and differences between the two cohorts

Similarities in characteristics among the groups

- Co-occurring mental health conditions were prevalent in both cohorts.

Differences in characteristics between the groups

- Difficulties with emotional regulation were present in both groups but were more prevalent in the early-onset group.
- Early-onset participants tended to experience difficulties with emotional regulation, including social anxiety disorder, much earlier in life compared to the late-onset participants.
- Early-onset participants experienced a loss of control over alcohol and became alcohol dependent more rapidly, compared to the late-onset group, whose problematic drinking and alcohol dependence was gradual.
- Growing up in a family environment where drinking alcohol was normalised, was more prevalent among early-onset participants, compared to late-onset participants.
- Late-life events, as risk factors for increased alcohol consumption were far more prevalent among the late-onset cohort compared to the early-onset cohort.
- Challenges to identity and self-concept was the most prevalent risk factor for problematic drinking among the late-onset group.
- There was a sub-group within the late-onset cohort who had been long-term heavy drinkers before their drinking became problematic.

4.4.2 Concluding remarks and implications

The study compared the retrospective, active drinking voices of early- and late-onset problematic drinkers. Most of the psychosocial characteristics that emerged from the participants' narratives, e.g., comorbid mental health challenges and difficulties with emotional regulation, have been well documented in the literature on problematic drinking, certainly in early-onset problematic drinking and to a lesser degree late-onset (e.g., refer to literature review). Regarding the late-onset cohort, the findings on major life events and challenges to identity and self-concept are particularly interesting and is something that could have implications for many 'social drinkers' approaching retirement. The phenomenon is not only

worthy of further investigation, more importantly, it is something the demographic the current research is concerned with, should have a greater awareness of, which is achievable through good dissemination. Research can only assume the status of being useful, when the relevant people know of it and more importantly, apply it; in this instance that means, the demographic being investigated and the health and social care professionals they are most likely to encounter.

The findings of this exploration of the active drinking voices of both groups of problematic drinkers has addressed the overall aim of this chapter/study by investigating and considering the psychosocial characteristics of both cohorts of problematic drinkers, the similarities as well as the differences (listed above in 4.4.1). It should be emphasised that although there were many different psychosocial characteristics between the two cohorts, the overarching similarity between the two groups was a high prevalence of comorbid mental health conditions. It is important to consider why MPL did not feature in this chapter/study. This is because the dynamic impact that retirement or loss/change of job had on the identity, self-concept and (lack of) self-esteem among the study's participants led to them experiencing a complete lack of MPL in their lives.

This lack of MPL reflects Frankl's (1963) existential vacuum concept and the notion that addiction (in this instance problem drinking), along with "depression and aggression", form what Frankl (2011, p.26) posited as a "mass neurotic triad" that are, in part, responsible for promoting an existential vacuum and consequently, a lack of MPL. The relationship between a lack of MPL and 'active' problem drinking is widely recognised (Mamić et al., 2024; McInerney et al., 2024; Song et al., 2018). The positive role of MPL is fully explored later in the thesis, in chapter six, and to a lesser degree in chapter five. For now, though, the focus remains on the narrative accounts of the participants. The following chapter explores the narratives of the same participants. However, in contrast to the evidently negative voices of

active drinking that emerged in this chapter, the participants' narratives in chapter five are framed within the positive and hopeful voices of recovery, in which they talk about, among other things, how they were able to move away from, and "out of addiction" (Dingle et al., 2015, p. 1), which encompasses, in part, (re)discovering MPL.

Chapter endnotes

1. In A.A. there are two schools of thought on the correct usage of the verb 'recover', in the context of the construction of sober identities. On the one hand, there is a preference for 'recovering', or being 'in recovery', which implies that rehabilitation from problematic, dependent drinking, is an ongoing process. On the other hand, there are those who prefer using the verb in the past participle, i.e., 'have recovered'. The argument is further clouded by the usage of the verb's past participle many times in A.A.'s main text, commonly referred to as the 'Big Book' (A.A. 2001), which informs the A.A. programme. For example, the forward to the first edition (reprinted in all subsequent editions) states, "We of Alcoholics Anonymous, are more than one hundred men and women who have recovered from a seemingly hopeless state of mind and body. To show other alcoholics *precisely how we have recovered* is the main purpose of this book" (p. iii). By italicising the book's main purpose, the authors leave little doubt as to their preference. This preference is further highlighted in the opening sentence of chapter two of the Big Book (There is a Solution), "We, of Alcoholics Anonymous, know thousands of men and women, who were once just as hopeless as Bill. Nearly all have recovered. They have solved the drink problem" (p. 17). Recovering or recovered? The debate, particularly among A.A. members, is ongoing. For a fuller understanding of the usage of language in the construction of sober identities, see Doukas and Cullen (2009); White (2000).
2. For a more comprehensive understanding regarding self-reports and memory, see Davies (1987,1989).
3. The 18 interview transcripts amounted to 228 A4 pages in total and are too long to include in the appendices section at the end of the thesis document. They are securely stored in Leeds Trinity University's cloud storage. Access (i.e., a link) to these files is available on request from the Chief Investigator.
4. The combined experiential statements, clustering of experiential statements and personal experiential documents, amount to hundreds of pages of documentation, and similarly to the interview transcripts, were too long to include in the appendices section at the end of the thesis document. An example of each of the documents involved in the interpretative phase of the study is included in the appendices. However, in common with the clean transcripts, they have been securely stored in Leeds Trinity University's cloud storage, and access (i.e., a link) to these files is available on request from the Chief Investigator.
5. For a fully informed understanding of the analytical process undertaken of the participants' transcripts in this study, in the context of their 'active drinking voices', scrutiny of this chapter's appendices is recommended.

CHAPTER FIVE

VOICES OF RECOVERY

"…. it's not recovering from you know an addiction, it's recovering, it's recovering, it's becoming your full potential, that's a lovely, that's a lovely definition."
(Steffen, late-onset)

5.1 INTRODUCTION

Defining recovery has evolved considerably since Jellinek's (1960) much cited treatise on problem drinking, *the Disease Concept of Alcoholism*[1], which according to Kelly (2019) has all too often been mis-interpreted and under-valued. Jellinek (1946, 1952) also conceptualised the descent into alcohol addiction[1], naming 43 temporal symptoms, categorised over four phases: pre-alcoholic phase, prodromal phase, crucial phase and chronic phase (*Appendix 5.0*)[2]; he did not, however, conceptualise a contrasting model of recovery. Max Glatt, founder of the first (NHS) detoxification and rehabilitation centre in the UK (Glatt, 1955), later added the recovery phases, and conceptualised the dual addiction-recovery model graphically, in the form of a V-shaped chart (*Appendix 5.0*). Glatt's Chart (Glatt, 1958, 1970) is commonly, and misleadingly, referred to as the *Jellinek Curve*. However, Jellinek's and Glatt's substantial contributions to defining problematic drinking, and in Glatt's case, definite phases of recovery, concentrate on one extreme pole of Best's and Hennessey's (2022) continuum (discussed earlier in the text). In contrast, contemporary definitions aim to capture a wider and more inclusive range of problematic drinker types (e.g., White 2007). The verbatim extract from Steffen's narrative, taken from the U.S. government's Substance Abuse and Mental Health Services' (SAMHSA, 2012) working definition of recovery, is an example of how defining recovery has evolved since Glatt's Chart. The full SAMSHA version defines recovery as: *A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential* (p. 3).

Steffen's preferred definition was not included in the earlier discussion on definitions of recovery. Nonetheless, the SAMHSA definition fits comfortably alongside the other leading definitions on a continuum of problematic drinking (e.g., Laudet, 2007; Panel, T.B.F.I.C.P, 2007; White 2007; UK Drug Policy Commission, 2012). These leading definitions represent a move away from paradigms, in which alcohol and other drug problems are viewed in terms of pathology and biopsychosocial interventions, towards a paradigm that focusses on a "recovery-orientated systems of care", as the solution to these problems (White, 2007, p. 229). The notion of a paradigm shift is the preamble to White's (2007) rationale and explanation for his own definition of recovery, presented in full, earlier in Chapter three (see p. 102). Nonetheless, the introduction of this chapter seems like an appropriate location to repeat the conclusion of White's (2007) definition, "*develop a healthy, productive and meaningful life*" (p. 236), because it positions having a *meaning* in life as an important and integral component of recovery, which is the theoretical underpinning of the current thesis.

There is too, a growing, but less dominant narrative that views recovery, not in terms of abstinence, but rather harm reduction, or as a continuum involving both (Morris et al., 2023; Witkiewitz, & Tucker, 2020; Witkiewitz et al., 2020). The primary aim of the harm reduction model, is to limit the adverse effects of harmful alcohol consumption and problematic drinking, regardless of the individual's goal being abstinence (Marlatt & Witkiewitz, 2002). This perspective of recovery has been defined by Tucker & Witkiewitz (2022) as "a dynamic process of behaviour change in which improvements in biopsychosocial functioning and life satisfaction are fundamental" (p. 14). If the harm reduction definition of recovery and the abstinence-based model, as practiced, for example, by A.A. were located on Best's and Hennesy's (2022) continuum, they would likely be situated at opposite poles.

Recovery then, holds different meanings for "different stakeholders" (Witkiewitz et al., 2020, p. 2), including, for instance, leading academic researchers, clinicians, healthcare

professionals, and people with lived experience of AUD/problematic drinking. Because they have been directly affected by the adverse physical and psychological consequences of problematic drinking, it can reasonably be argued that the most important stakeholders in Witkiewitz's and colleagues' (2020) list are individuals with lived experience of problematic drinking (Collins et al., 2016; Jacobs, 2018); along with their families (e.g., Haeny et al., 2018; Leonard, & Eiden, 2007; McCrady, & Flanagan, 2021; Rothenberg et al., 2017). An essential consideration in defining recovery in the current context, therefore, is what recovery means to those most affected by problematic drinking. The individual's conceptualisation of their own recovery, however, will be informed by several factors, including gender (Laudet, 2007) cultural and societal norms and attitudes (Best & Hennessey, 2022), one's spiritual or religious beliefs (Laudet et al., 2006) and the meaning that these constructs hold for the individual in recovery (Laudet et al., 2006; Nelson, & Ogilvie, 2022; White et al., 2006). Moreover, an individual's concept of recovery, particularly those who are members of mutual-aid groups, will likely have been further influenced, in varying degrees, by the tenets of the organisation to which they are affiliated (Glassman et al., 2022a; Williams, 2021).

Koch (2019), for example, who explored the narratives of nine U.S. veterans in recovery, reported a single, joint definition for the nine participants, "as total abstinence and enhancement of quality of life" (p. 112). The authors' summation corresponds with a 12-step perspective of recovery, which is not surprising, because the participants were all long-term members of A.A. Although the authors reported a "diversity in participants" and "different demographic variables" (Koch, 2019, p 116), they rather oddly, did not consider the participants' homogenous membership of A.A. as a single source bias. In contrast, Nelson et al. (2023) explored the lived experiences of AUD and recovery pathways from the cultural lens of urban American First Nation and Alaskan Native communities. Nelson and colleagues (2023) found that their study's cohort (n = 31) conceptualised recovery within a cultural

framework, which included meaningful, cultural and spiritual activities, and community and indigenous peer support. Additionally, for the American First Nation population, who are a marginalised minority, recovery "must ensure basic needs are met and thus go beyond a focus on abstinence achievement and maintenance" (Nelson et al., 2023, p. 153), a position closely aligned with the RC (Cloud & Granfield, 2001) model of recovery. Moreover, recovery is not a static construct, it changes over time (Laudet et al., 2002; Margolis et al., 2000; Vaillant, 2009), as does the individual in recovery (Best, & Aston, 2015; Martinelli et al., 2020) and their personal definition of recovery (Laudet, 2007).

There is, however, a paucity of empirical information on long-term recovery and how its meaning changes over time, particularly in the context of a growing demographic of older individuals with long-term recovery. For example, 31% of the respondents to A.A. GB's (2022) most recent survey, reported having between five and ten years of continuous sobriety, with 45% reporting over ten years continuous sobriety, many of these with multiple decades. Moreover, according to Best et al. (2015) based on the first UK Life in Recovery survey, the average age that people in the UK begin their recovery journey is 38.2 years-old (Female, m = 37.2; Male, m = 39.2)[3]. Taken in the round, both sets of statistics indicate that there are likely to be many individuals experiencing both long-term recovery and the advancing years that accompany it. Ageing, of course, presents new challenges to the individual in recovery (Laudet et al, 2002; Gubi, & Marsden-Hughes, 2013; McInerney et al., 2021). Older voices of recovery, and the temporal adaptions of the meaning of recovery, are particularly relevant in the context of the participants in the current study, many of whom are in long-term recovery.

Of the many dictionary definitions of the noun 'recovery', two are relevant in the context of the current discussion: 1) *'the act or process of recovering, especially from sickness, a shock, or a setback* and 2) *the regaining of something lost'* (Dillons, 1990). Problematic drinking is undoubtedly harmful and injurious, and the problematic drinker loses many things

because of their unhealthy relationship with, and dependence on alcohol; for example, physical and mental health, relationships, finances, self-esteem and identity (this, of course, is not an exhaustive list). This chapter aims to explore and compare the similarities and differences between the early- and late-onset participants' 'voices' in the context of their understandings of recovery. In doing so, the chapter addresses three of this thesis' research questions: Q.2.) *Investigate the psychosocial characteristics of late-onset AUD/problem drinkers in recovery and compare them with the psychosocial characteristics of early-onset AUD/problem drinkers in recovery*; Q.3.) *Explore and compare the role of MPL, between early- and late-onset problem drinkers, who are in recovery*; Q.4.) *Investigate and compare the recovery pathways of early-and late- onset problem drinkers in recovery.*

5.2 METHOD

The methods for this study and the previous study are shared (refer to 4.2, p. p. 110-116).

5.3 RESULTS

5.3.1 Demographics

This study and the previous study, '*The Active Drinking Voice*', share the same participants (refer to Tables 4.1 and Table 4.2, p. 118). The mean years in recovery for the early-onset cohort was 12.37-years, this was considerably more than the late-onset cohort (m = 4.6-years).

5.3.2 Experiential group themes

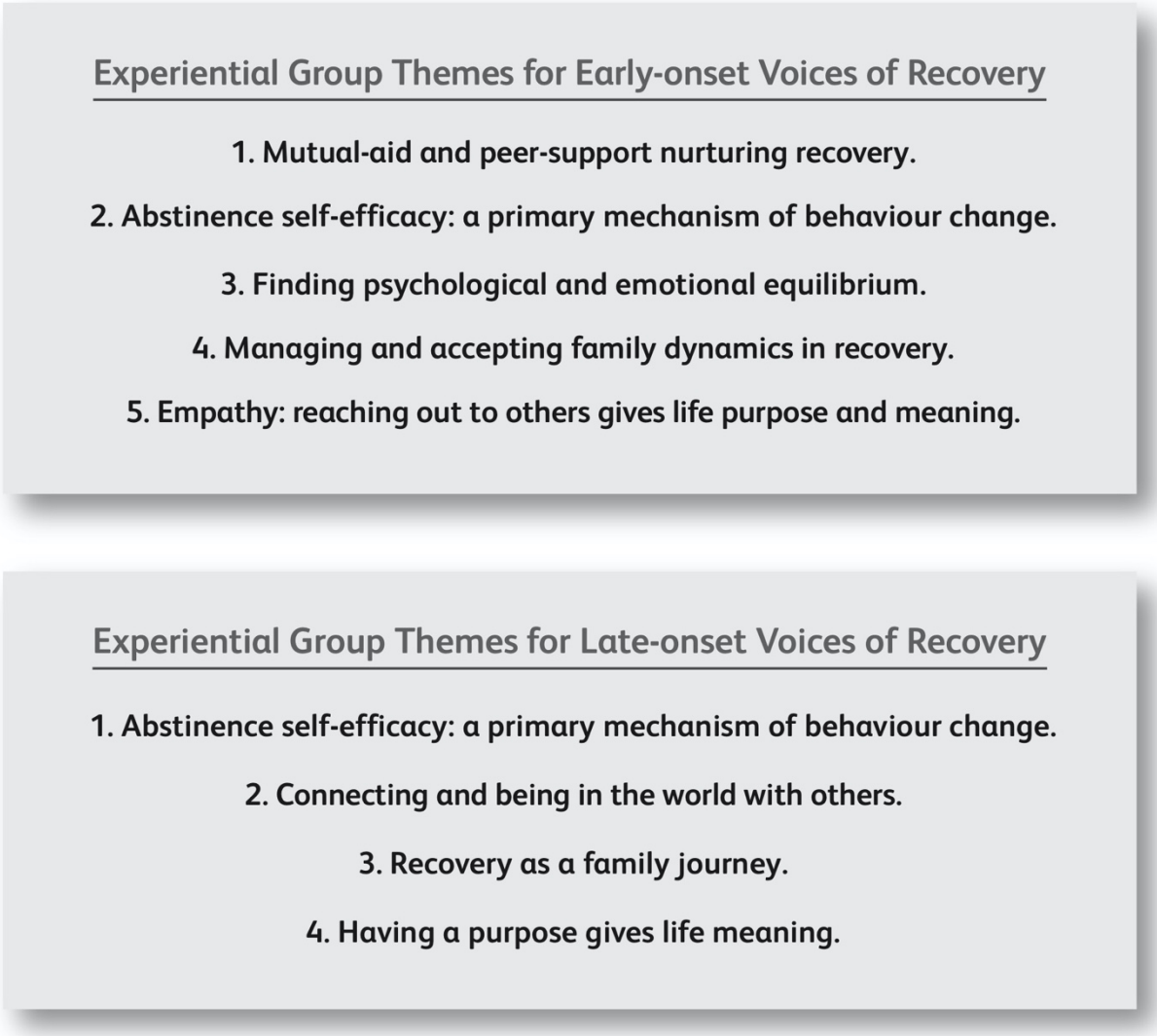


Figure 5.1.

Group Experiential Themes.

5.3.3 Summary of the narrative account of group experiential themes

This section reports on the *Voices of Recovery* of the study's 18 participants and presents and commentates on the extracts taken from their individual personal experiential themes, that constitute the more collective group experiential themes of both groups of problematic drinkers. There were a total of five GETs for the early-onset group and four for the late-onset cohort (Figure 5.1). In common with the earlier study, *The Active Drinking Voice*, each of the group experiential themes presented is preceded by a diagram (Figures 5.2 through 5.10), each of which show graphically how the participants' individual personal experiential themes maps

onto their relevant group experiential themes. Also refer to *Appendices 4.8 & 4.9*. For a fuller understanding of the analytical process undertaken of the participants' transcripts in this study, in the context of their 'recovery voices', please refer to *Appendices 5.1.EO.1 to 5.1.EO.9* and *5.1.LO.1 to 5.1.LO.9*

5.3.4 EARLY-ONSET GROUP EXPERIENTIAL THEMES

5.3.4.1 Early-onset Theme 1.

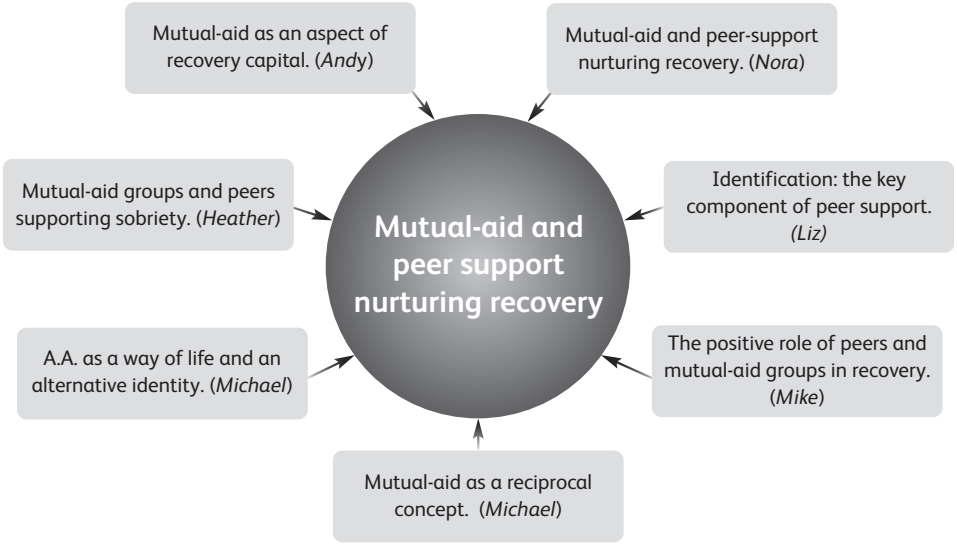


Figure 5.2. *Early-onset group experiential theme 1 and constituent personal experiential themes.*

The first early-onset group experiential theme, indicates that peer-based recovery support usually (but not always) found at mutual-aid organisations, had been fundamental to recovery for six of the group's participants. Of course, this is not a surprising revelation, peer-based recovery support is arguably, the most important component of all mutual-aid organisations (e.g., A.A., SMART Recovery) and is an essential component of many of the leading models of recovery (e.g., RC, Best et al., 2021a; Chiu et al, 2010; Humphreys, 2004; SAMSHA, 2012). Moreover, peer-based recovery support for alcohol and other drug problems has a long history, that can be traced back 275 years (White, 2009). The participants' extracts from this first group experiential theme, suggest the most prominent feature of peer-based recovery support is the simple process of identification. In the first instance, identification has a powerful, liberating

quality, demonstrating to the individual in recovery that they are no longer alone and that others too, shared the same experiences and relationship with alcohol, this redeeming process is expressed succinctly by Liz and Mike, Andy and Nora.

> *I did go to an organised group called SMART Recovery, and that was face-to-face, and they were brilliant […] Everything they said made sense. The people were, they were lovely and the support was great […] it helped me understand, that other people with the problems that were the same, or greater than mine, had stopped. So that was a, a landmark.* (**Liz**)

> *... you're confused, and it's a new world, and that's why AA's great for you. You've got other people to share that journey with. [….] you suddenly realise, oh yeah, I know I'm going through that now, I'm doing that, I'm behaving like that, and I've seen that in someone else.* (**Mike**)

> *I knew I was among friends or people who at least knew what I was going through. Ehm, couldn't do AA because ehm, I don't believe that I'm, I'm an unrecoverable alcoholic and I'm not 'gonna give up my personality to some fictitious being above. But SMART is scientific. It's based on control behaviour therapy, cognitive behavioural therapy, rather. Ehm, scientific principles that I can believe, and that seems to work for me.* (**Andy**)

> *And although I had built relationships with, you know, people within recovery, they were going to AA […] I managed to get myself to the meeting. […] they offered me a half a cup of tea. Ehm, and I had a breakdown while I was in the meeting. […] So, there was, there was something in the room which made me think. 'right, let's give this a try'.* (**Nora**)

<u>Conclusion to Early-onset Theme 1</u>

Although not all the participants' personal experiential themes mapped onto this group experiential theme, the narratives of those who did contribute to this theme suggest that

identification is the foundational underpinning of all mutual-aid organisations. The collective narrative of the six participants that constitute this theme can be interpreted as one of 'hope', of knowing that fellow sufferers have found a way to recover, and that their example of recovery was possible for them too. Hope, in turn, is related to (Feldman & Snyder, 2005; Hedayati & Khazaei, 2014; Wnuk et al., 2012), indeed, mediates MPL (Cotton Bronk et al., 2009). In this context, hope can be viewed as the beginning of (re)discovering MPL. The hope and meaning that consequentially emerged in the participants narratives in the early-onset cohort, was supported by membership to mutual-aid organisations and access to peer-based recovery support, two tangible constructs that, in turn, generate two powerful and closely-elated psychological constructs, 1) *identification*, and 2) *the power of example*. The participants' narratives suggest that the process of identification they underwent as mutual-aid 'new-comers' was emancipating. To know that others feel or have felt the same as they felt was, indeed, a liberating experience. Moreover, the participant's narratives illustrate the power of example inherent in peer-based recovery support, which in turn, can gives one a purpose in life to aim for.

5.3.4.2 Early-onset Theme 2.

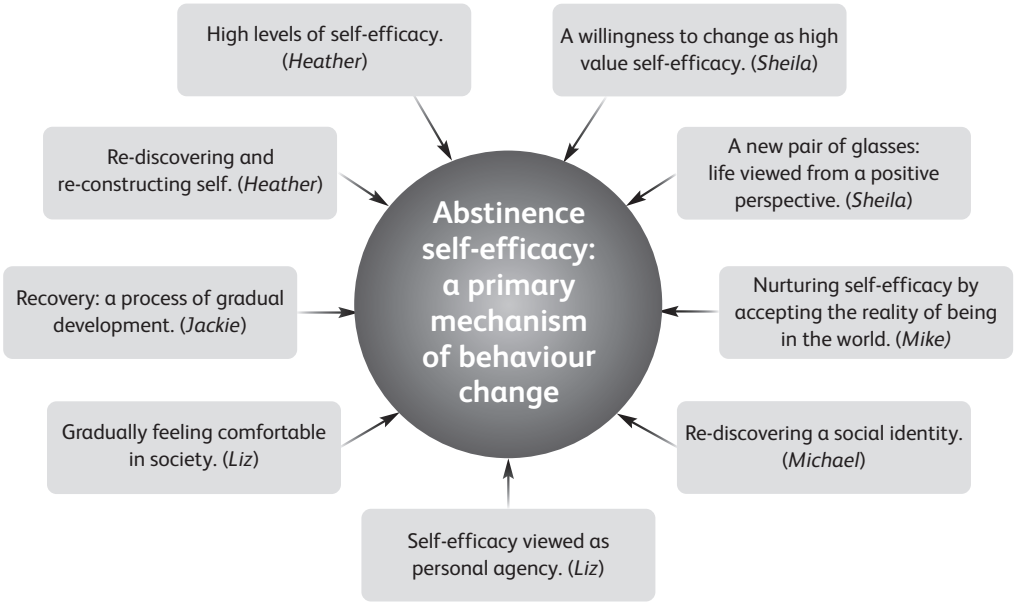


Figure 5.3. *Early-onset group experiential theme 2 and constituent personal experiential themes.*

This theme summarises the transformative experience of being and existing in a different world, of viewing life through a different lens, nurturing a positive attitude, and accepting a commonly shared reality. Central to the theme is the participants' realisation of the ability to access and generate abstinence self-efficacy, something that is explicitly referenced by four of the theme's constituent personal experiential themes and implied by the remaining personal experiential themes. Abstinence self-efficacy (DiClemente et el., 1994) is the application of Bandura's (1977) original self-efficacy concept to alcohol abstinence. In essence, self-efficacy is the individual's perceived ability (self-belief) to undertake certain actions that will help them to achieve their goals, which in the case of the participants' behaviour in the current study, is the cessation of drinking. The demonstrative examples of their sober peers identified in the first theme, in effect, may have acted as social learning models (Bandura, & Walters, 1977), inspiring the participants to access (abstinence self-efficacy). Mike's abstinence self-efficacy for example, is manifested in his pragmatic life philosophy, Liz's and Heather's extracts are demonstrations of determination, while Sheila's willingness to behave differently, has resulted in being able to view life from a positive perspective.

> *I don't want to drink no more. I just don't want to drink no more, you know. […] Life doesn't ask for terms, it's whether I choose to put terms on it, and that's when I get upset. […] We exist, you know, we exist, and we make the best of it. But a little bit of planning is not a problem.* (**Mike**)

> *Ehm, and I know other people have said to me "ohh, how could you have stopped then?" But I chose to stop, I wanted to stop, and once I had started stopping, I, I never really wanted to go back. […] So, first of January twenty-twenty, I was just like, "right, I'm 'gonna do 100 days", and, and nine-hundred and thirty days later, I'm talking to you, and it's just been the best thing I've ever done.* (**Liz**)

> *So, then, then when I got to the hundred days, it was the day before my fiftieth birthday, I then carried on until, well, I'm still carrying on now. […] I threw everything I possibly*

> *could at it. But it was, like I said, it was do-it-yourself. It was reading quick lit, it was, ehm, Instagram, listening to podcasts. I did a lot of journaling.* (**Heather**)

> *I mean, I used to wake up and if it was sunny, it's a reason for a drink. Now, I wake up and it's reason not to drink. Ehm, you know, but it's not just AA, it's actually my perception of life. […] And I don't want to feel sorry for myself because every day you feel sorry for yourself, it's a wasted day…* (**Sheila**)

Additionally, the theme highlights that self-efficacy, often involves reconstructing a sense of self; discarding the shame, stigma and low-self of the 'addicted-self', replacing them with a confident and self-assured 'recovered-self'. Something expressed explicitly, for example, by contrasting Michael's retrospective 'Active Drinking Voice', with his current 'Voice of Recovery', highlights the degree of change required to promote recovery.

> *… I don't think I ever saw a tree because I was always looking down on the floor because I was always ashamed of myself...* (Active Drinking Voice)

> *You know, today I can walk the dogs and I, and I can do the things that, as I say, that normal human beings can do. […] I can be polite to people. Go into a shop and say, "thank you". […] I'm a fully paid-up member of the human race.* (**Michael**)

<u>Conclusion to Early-onset Theme 2</u>

The narratives of the early-onset participants in this study, place their drinking at the extreme and harmful pole of a problematic drinking continuum. The theme suggests that high-levels of abstinence self-efficacy, may have been the primary mechanism of behaviour change behind the participants' transformational journeys, from the existential challenges that accompany problematic drinking, to a new and completely different way of living and being in the world, i.e., recovery.

5.3.4.3 Early-onset Theme 3.

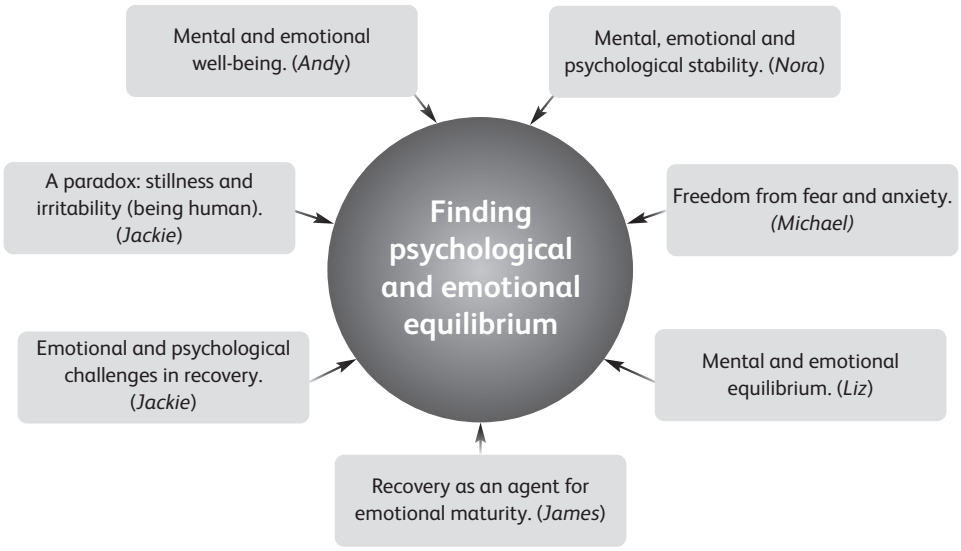


Figure 5.4. *Early-onset group experiential theme 3 and constituent personal experiential themes.*

The first early-onset theme in the previous chapter, 'The Active Drinking Voice', identified an 'emotional immaturity' among the cohort. The participants' discourses in this theme express how the clarity of sobriety creates a positive space in which they can acknowledge and better understand their emotions and their mental health. That said, the first extract, taken from Jackie's narrative, shows that emotions can sometimes be difficult and challenging in recovery too; emotions, after all, are a measure of what it means to be human. The difference is that sobriety affords Jackie the psychological and emotional space to cultivate and nurture methods, that have enabled her to navigate challenging emotions and negative thought processes, that she refers to as the *dark time of the soul*, without having to self-medicate them with alcohol.

> *I know, I understand I've been ill and I understand, you know, the brain fog or whatever, is problematic with this illness, with COVID. Umm, but I have felt absolutely despairing, absolutely despairing. And the only thing that helps is to, you know, ring my sponsor, and just be told that this is like, basically the dark tea-time of the soul. You know, I'm getting old. I'm finding it more and more difficult to sort of cope and I'm not, you know, not particularly happy. I can't seem to get rid of it. But you know, the difference is, I'm not rushing out and picking up a drink or drugs.* (**Jackie**)

Nora is coping with the same chronic, comorbid mental and physical health conditions in recovery (bipolar disorder and diabetes), that she had when she was drinking. Although Nora's bipolar disorder is still present (she has been sectioned in sobriety), recovery means that she can look after herself better and manage her medication, something she was unable to do when she was drinking problematically. In the context of her recovery, the verb 'manage' takes on a completely different meaning; for Nora, being able to 'manage' her medications, is an existential necessity, and evident in her narrative. In common with many individuals who suffer with bipolar disorder, it usually takes a while to find the appropriate drugs to effectively treat their condition (e.g., Maassen, et al., 2018; Poole et al., 2012; Senner et al., 2021); Nora believes she is now being prescribed the correct medication.

> *I'm also, ehm, I'm bipolar type 1. So, I have been sectioned a couple of times without drinking, […] So, medication wise, I am on quite a lot. Ehm, but I've been really well since I last came out of from being sectioned, I was in a psychiatric unit, ehm, for ten weeks. Came out of one, and I still wasn't well, and ended up back in another.*
>
> *I had two psychotic episodes. Ehm, I mean, I was under a lot of strain. My best friend was dying in …. one of my best friends was dying in hospital. […] But, you know, that was very stressful at that time. Ehm, could that have been part of it? They don't really know, they just know it's a chemical imbalance in the brain. You know, and I wasn't using any substances or alcohol. Yeah, so I do take an antipsychotic every night, which just keeps me level, you know. I'm, I'm, I'm probably, the wellest I've been for a long time.*
>
> *… my life has changed significantly for the better. Ehm, with not drinking alcohol, you know, mental health is a lot better. Ehm, you know, I'm on the right medication. I look after myself more because I'm a diabetic and insulin dependent. You know, those are things that I couldn't do when I was drinking. You know, it didn't matter. So, I would, you know, would have been, ehm probably in an early grave.* (**Nora**)

In common with Nora, finding psychological and emotional equilibrium in recovery for Liz, was not a straightforward, sudden event that followed cessation of drinking alcohol. Although her depression and anxiety waned considerably when she stopped, many of her more rigidly fixed behaviours, were still present. Liz, almost two and half years into recovery at the time of the interview, similar to many individuals in early sobriety, is realising that behaviours, are deeply rooted in one's individual's being, and are not that easily transformed. However, the noticeable difference in recovery, is that she is aware of her embedded behaviours, which means that she now has the opportunity to change them, should she so wish.

> *So, actually, my life became easier when I stopped drinking, I didn't have to lie to people, I didn't have to take painkillers every day, I didn't have to lie to myself. I slept. I didn't have raging anxiety. […] However, there have been the occasional times when I've done things sober that I would have done when I was drinking heavily. That just brought me up a little bit short, I was like, 'ohh, shit', I'm doing this thing that I used to do when I was drinking, and now I'm doing it sober.* (**Liz**)

Michael experienced high levels of anxiety and had been fearful since he was a child, so when he found alcohol when he was growing up, he discovered a method of medicating and nullifying these negatively and mutually supportive, emotional protagonists, albeit temporarily. Paradoxically, it was fear, fear of dying, that prompted Michael towards recovery. After 13 years in recovery, and with professional help, Michael has overcome his irrational fears and anxieties. Managing emotions in early recovery was not easy, but now he is better able to regulate his emotions, evident in his positive attitude towards serious health challenges.

> *I didn't know how I could stop drinking. And it frightened me, I knew there was only one thing round the door, around the corner, and that was death.*
>
> *I found it hard to talk to people, found it hard to, to talk to men, mostly, for the first few months. […] And then, ehm, I done some work on myself with my counsellor in, in, in*

the rehab and was able to go out and I was able to talk to men, I was able to get to know men and I was able to talk to men…

and a year later, I got cancer, prostate cancer. […] I had radiotherapy. Twenty-two days, twenty-three days. Every day for twenty-three days. You know, it's in remission today. If, I'd been drinking, I would never have known about it. **(Michael)**

Conclusion to Early-onset Theme 3

Because of their dependence on alcohol, as suggested earlier in the text, the foundation of the participants' recoveries is based on abstinence. However, their narratives in this theme, show that cessation of drinking, is only the beginning of a journey to find or restore mental and emotional equilibrium. Again, they have discovered, or are discovering that, similarly to their behaviours, their psychological, mental and emotional problems are deeply embedded in their being. Their discourses show that recovery has afforded them the time and space to understand and address these problems.

5.3.4.4 Early-onset Theme 4.

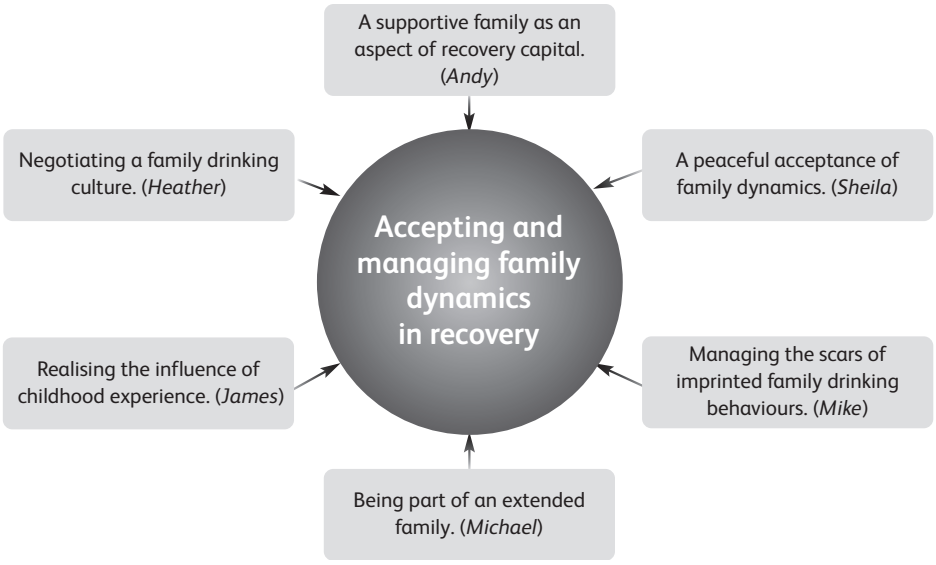


Figure 5.5. *Early-onset group experiential theme 4 and constituent personal experiential themes.*

According to the literature, the role of the family in recovery has most often been reported as an important and positive one, promoting social capital, a key component of recovery capital

(RC; Best, & Hennessy, 2022; Hennessy, 2017). However, the participants' narratives that constitute this theme, show that their individual family's reactions to their recoveries, were variable. Heather's discourse, for example, is one of high levels of abstinence self-efficacy. Heather had to negotiate a hostile reaction, from a family who were steeped in a drinking culture, a central theme throughout her narrative. Her husband, father and sister are heavy drinkers and are resentful that Heather has chosen recovery over alcohol. They lack any understanding, tolerance or empathy for Heather's sobriety. Why would they? After all, they are drinkers. Heather's relatively recent recovery is a challenge to their own relationships with alcohol; her sister's reaction, for instance, is extreme, she now ignores Heather.

> *... my family and everybody that is around me probably thinks that I've over-reacted by stopping drinking […] I'm sure my husband still thinks I'm a nutter to this day for doing it […] Like, you know, I think he thought it was a fad and after a hundred days I would, I would go back to my, my drinking self.*
>
> *My dad's, my da, I mean, he's in his eighties, he's already told me I'm on the wrong path, being sober. I mean, that's not very, very helpful, is it? […] mum's feeling that somebody that doesn't drink isn't normal, right?*
>
> *My sister, it's, it's always been again …. We had the same upbringing, her drinking has always been actually worse than mine and her behaviour has always been worse than mine […] And the sad thing is now, is she kind of like doesn't want anything to do with me either because I've stopped drinking.* (**Heather**)

Although Sheila's family relationship is not as hostile as Heather's, indeed her family are supportive. However, after many years in recovery, she has not yet regained the trust of her son. Their relationship is an ongoing strand in Sheila's narrative and although her son, definitely does not want to see his mother drinking again, he is at the same time, ambivalent about the methods she employs to maintain her sobriety.

> *My, my ex is he wasn't supportive at first, he is very supportive now. Ehm, my son will say to me, 'Oh, you've been to one of those meetings", and he won't say anything more than that because he doesn't live with us.* (**Sheila**)

Sheila has gathered enough self-knowledge in recovery, to know that she is powerless over the current, imperfect relationship she has with her son, acceptance being her only option.

> *I have accepted it, because the thing is, I think if you don't, I'm back to the, you know, either passive-aggressive, or I'm back to the actual keep questioning and going over things. Ehm, you know, and I, I don't 'wanna do that. I've, I've got, I've got a second chance on my life and I'm not wasting a second of it being miserable.* (**Sheila**)

Growing up in a family drinking culture not only influenced Mike's drinking behaviour, but his childhood experiences of his family's drinking is imprinted in his psyche, in his being. His recovery voice references, retrospectively and reflectively, a 'place of safety' he discovered when he was a child; a place he would go to on family holidays to find sanctuary from the chaos of the grown-ups and alcohol. A.A.'s suggestion of finding a 'Power greater than oneself', is a personal construct. In recovery, for Mike, it isn't so much a Higher Power, it is a thought, a technique that takes him to a place of refuge, it is simply being mindful.

> *Well, I was only a very small child, so all of that stuff was going over my head, all the arguments and all of that. It was all going over me and I was I was only, like, under five anyway. Long story short, I was up in the roof and the pigeons used to sit on the roof and coo in the morning, you know, like they make that, blah, blah, blah, blah, all of the time, you know. And I was very content there, you know, I felt very safe there and so that became my thing, that was my place. Take myself out of this and put myself in that loft room knowing the whole family is all downstairs.*
>
> *So that became my saving. So, then I thought well, how am I going to do this religion thing? You know the God consciousness and all that shit. And I thought I know, I'll*

combine it to … I'll stick to pigeons cause they're fucking everywhere, so if I hear one or see one … I made a mental note to say "Do you know what, Mike? You're all OK. Everything is going to be alright. You're doing the right thing. Blah blah blah". So, every time I see a pigeon, I've made myself have that little thought, as a trigger. So, that's how I that's how I got round it all. So, you know pigeons … So, when I say oh, pigeons are my Higher Power, they go "what!" I use them as a safe place, it's a link to something bigger and better and wider. And then … as far as religion is concerned, I can't stand organised religion it drives me up the fucking wall. (**Mike**)

Conclusion to Early-onset Theme 4

The role of the family in recovery from problematic drinking is a major area of investigation, and a considerable body of work is available on the topic (e.g., McCrady, & Flanagan, 2021; Moos, & Moos, 2007; White, & Savage 2005). The narratives of the participants in this theme highlight how variable family reactions to recovery can be. As the selected extracts above show, family drinking cultures and alcohol-related events create deeply entrenched memories and behaviours.

5.3.4.5 Early-onset Theme 5

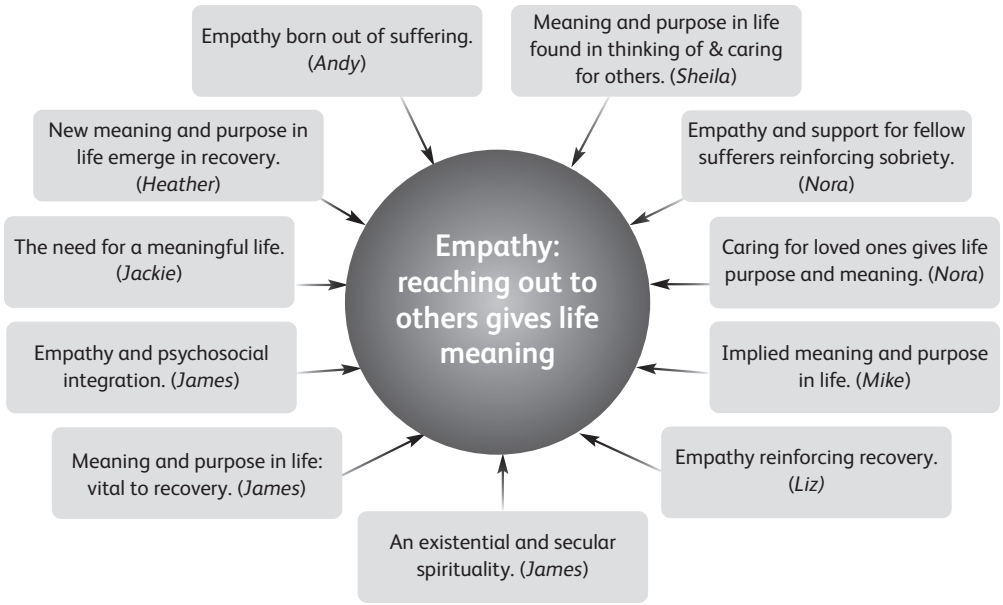


Figure 5.6. *Early-onset group experiential theme 5 and constituent personal experiential themes.*

The relationship between empathy and meaning was present in the personal experiential themes of eight of the nine early-onset participants. The example extracts suggest that empathy for other people who are suffering, fulfils two psychological functions for the individual in recovery. Firstly, it reinforces sobriety, which in turn, gives the individual in recovery a purpose in life and therefore meaning. Indeed, apart from its primary existential purpose, recovery for the early-onset participants in the current study, among other things, is about finding meaning in life. The participants' narratives are all very different aspects of the theme that is bound together by the common strands of empathy and meaning. A constant throughout Liz's interview was the need to share her experiences of drinking and sobriety, with her peers in early recovery, reflected in her self-effacing statement about not being qualified to help others in recovery. Similarly, Andy expresses humility at being chosen as the recipient of a new liver, over someone else, whom he considered to be more deserving than himself. James' and Nora's narratives are further examples of reinforcing one's own recovery by supporting peers in recovery.

> *... I've got enough emotional fuel to be able to help other people. But there's a sober person, there's a part of me that tries to help. I know for an absolute fact I'm not qualified to help, the only thing that I can do is talk about my experience.* (**Liz**)

> *I was concerned that, 'what if the guy in the next bed was twenty-five years old and had three kids'. Whereas I'm 63, no children, no responsibilities, why would they choose to give me a liver over him and that was a concern of mine.* (**Andy**)

> *... there's a role that I want to develop in, in long-term recovery, which is the role of a recovery coach. Somebody who would work one to one with four or five people, who are on their feet and sorted, but need some additional support in pulling their plan together.* (**James**)

> *... I was a volunteer at CGL, I was helping others. Ehm, and I really enjoyed that, you know. And it helped me in my recovery. […] I was volunteering at CGL, and I was feeling good about myself …*
>
> *I've got a girlfriend whose partner is an alcoholic, he's been through many rehabs and he still can't put the drink down for whatever reason. And I say to my friend, you know, ring me anytime, you know, if it gets too much.* (**Nora**)

Mike's discourse about his mother's Alzheimer's, is full of pure compassion and love. He seems to have nurtured a deep level of acceptance about no longer having the mother that was always there for him, no longer being there. In recovery, Mike has come to understand that love is not transactional, rather it is unconditional; Mike's discourse is full of meaning.

> *I think a lot of people get angry because they lose what they think they own and I don't own my mum, I don't own my mum's memory. […] I am really a firm believer in unconditional love. I can love someone, and I don't have to have that returned and I don't have to see them. I don't even have to stand next to them, I don't have to. And you know, I don't even have to talk to them, either. You know, I can still have compassion and feeling for someone. And that doesn't have to come back.* (**Mike**)

It is interesting that Jackie, the participant with the longest time in recovery (35 years) struggles to find meaning in her life. After spending her entire recovery in A.A., she is aware that she needs to find something new, something that is challenging. Her narrative suggests that recovery is a process of development in which, finding a purpose gives one's life meaning. That said, despite wanting to try so many other things, there is a reluctance, an anxiousness, even a fear, about further development of her being outside the confines of an A.A. perspective.

> *I struggle with this all the time, you know, trying to find meaning and purpose in my life. I'm not doing very well, and to be perfectly honest, the only thing that I can say that gives me a shred of meaning or purpose is helping others to recover. You know*

> *what? What, what little bit I can do to help others. And then the whole service thing in A.A. You know, giving back to A.A., but that's become my whole core of my meaning of purpose. Without that, I don't know what it would be.*
>
> *Which is something of a conflict within me. I say that, because it's something I've been trying to do for a long time. […] I'm kind of thinking there are things that I really want to do.*
>
> *… all of my effort, all of my energy is going into A.A. and I can't ... You know, I just sometimes think if I didn't have that would I become a better gardener? Would I become, you know, better at making pots? Because if I put the amount of time, I've put into A.A., into other things.*
>
> *And to have the courage because I need to have a new phase of my life.* (**Jackie**)

Conclusion to Early-onset Theme 5

The last early-onset theme highlights the simple relationship between empathy and having a purpose in life. The participants' narratives suggest that helping other individuals, who are 'in the same boat', appears to take on greater relevance and meaning to those participants in relatively early to stable recovery (James, Liz, Nora). For the participants in long-term recovery (Andy, Mike), empathy appeared to take on a broader meaning, beyond being a life purpose, supporting others in recovery and one's own recovery. It is interesting and revealing that Jackie, who is still deeply involved in the A.A. 'service to others' model, is struggling to find meaning in her life.

5.3.5 LATE-ONSET GROUP EXPERIENTIAL THEMES

5.3.5.1 Late-onset Theme 1.

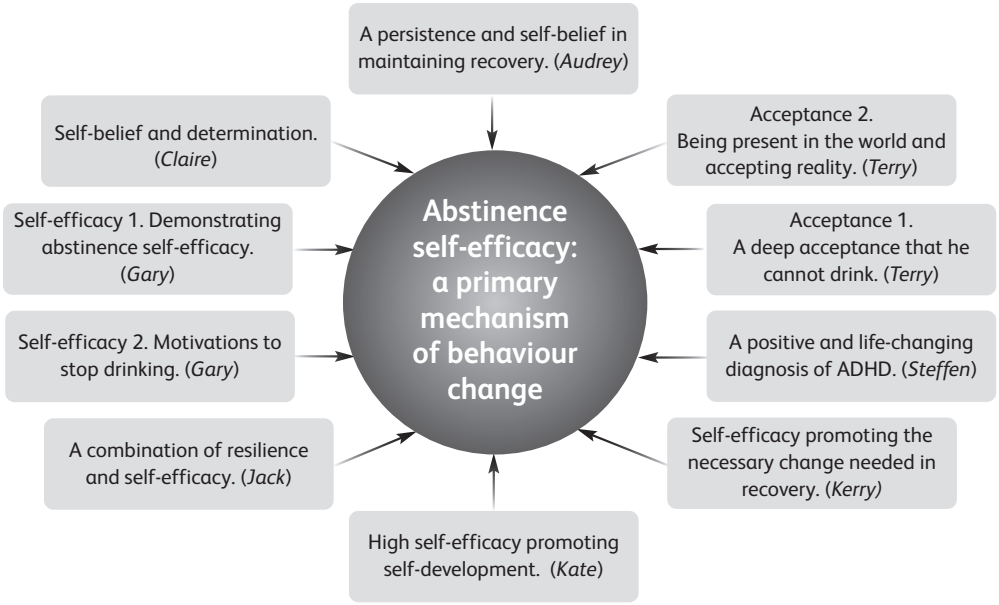


Figure 5.7. *Late-onset group experiential theme 1 and constituent personal experiential themes.*

The first late-onset and the second early-onset themes share the same label. Eight of the nine participants contributed to this late-onset group experiential theme (ten personal experiential themes in total), compared to six in the early-onset version, suggesting a high level of abstinence self-efficacy across both groups. For the participants in both groups, abstinence is the 'foundation' on which their recoveries are based. Kate, for instance, contextualises her recovery as a developmental process.

> *... so, last year I trained to be a life coach. I think through looking at the psychology behind coaching — I haven't done any life coaching to anybody else, I've probably coached myself more — ehm and when you realise that these are just labels and they're, then they're not attached to your happiness or your contentment in life, or you know, real values, then ... ehm, I'm more at peace now.*
>
> *And you know, little things that because you are seeking and you are reading and you are learning, and this is part of our development. And they, they, you know, they tickle your imagination. And I feel as though even from twelve months ago, I am in a much*

> *better place, for lots of reasons, but it's 'gonna be, the bottom line has got to be through being sober. But that's the foundation.* (**Kate**)

The label for Kerry's personal experiential theme (above) which maps onto this theme, states that self-efficacy promotes the necessary change needed in recovery. For Kerry this has meant, gradual, attitudinal changes. Kerry now believes that her purpose in life "*is to sparkle*", but what does that mean? She explains that it is a multitude of things, the sum total of which means, being authentic, being whole, being herself.

> *My purpose in life now is to sparkle. [...] Ehm, I've lost the need to always be looking to be somewhere else, doing something else, go somewhere else. I've got that ability just to sit now, you know.*
>
> *I don't punish myself as much as I used to. You know, I have no aspirations of ... I work four days a week, I'm happy with four days a week.*
>
> *I'm not trying to fix everybody with, you know, it's just, you know ... Because that was, was a big problem of mine, I, I thought I could fix everybody.* (**Kerry**)

The language Jack uses to describe abstinence is pragmatic and rational. In essence, his philosophy is existential, he doesn't want to be identified by stigmatising terminology, i.e., 'recovering alcoholic'. 15 years of sobriety is evidence that Jack's pragmatic perspective on sobriety works for him. abstinence self-efficacy is not to be confused with a 'clenched-fist' type of willpower, rather it is, simply, a determined, self-belief and willingness to undertake certain actions, to achieve one's goals and maintain them. Jack's sobriety was challenged after just eight months of sobriety when he received a diagnosis of prostate cancer.

> *I could control my alcohol I can't control the cancer. And that made a big difference to me and it kind of goes against, for example, the whole twelve-steps principle, programme, and that first step about losing control to alcohol. No, I just don't drink, I'm not in recovery. I'm not a recovering or recovered alcoholic, the way it's worked*

> *out for me is I just don't drink. So, I don't talk about alcohol that much. I was dependent on alcohol for a period and that kind of … is my approach.* (**Jack**)

Claire shares Jack's pragmatism, determination and self-belief. Claire's journey to abstinence, now totalling seven years, began with a drinking reduction programme, aimed at helping people to gradually reduce their alcohol intake.

> *The key thing was, I wanted to stop. Even after I had tried umpteen times.*
>
> *... and I'd got to the point where I literally was pouring most of it down the sink, and having a glass, a big glass, you know, one like that (indicates with her hands the size of a big glass), not a few ones, but it was one glass. It suddenly struck me that it was just the height of stupidity. And that's when I stopped. But I'd been getting help for about two or three weeks before that. So, whether that was just that light bulb moment or something else …*
>
> *I went to a programme that was called RAMP (Reduction and Motivation Programme) and that was about education. So, it was about … I was with a group of people that kept changing and … but it was a ten-week programme ...* (**Claire**)

Conclusion to Late-onset Theme 1

The participants' narratives in this first late-onset theme, suggests that along with mutual-aid groups or community drug and alcohol services (for the participants' affiliations, refer to Table 4.2, p. 118), their recoveries were supported by abstinence self-efficacy. Moreover, their narratives suggest that abstinence self-efficacy is a personal, cognitive attribute, that one can access, nurture and apply successfully, in order to facilitate behaviour change. It is important to emphasise that abstinence self-efficacy is not willpower, it is having enough self-belief to be able to access and utilise a positive and liberating cognitive resource.

5.3.5.2 Late-onset Theme 2.

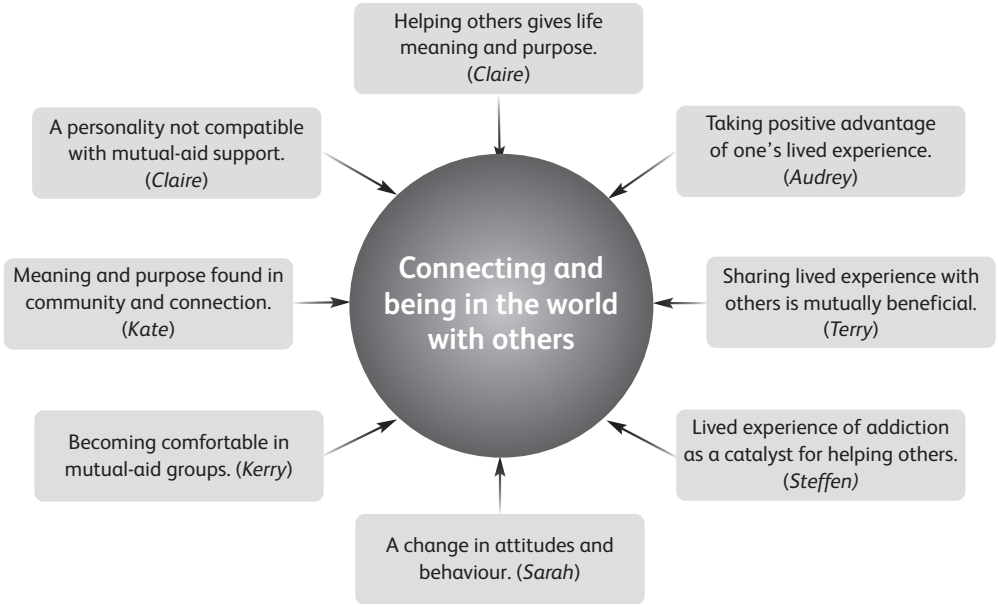


Figure 5.8. *Late-onset group experiential theme 2 and constituent personal experiential themes.*

Essential components for many people in recovery, developing social networks and connecting with other people is high value social recovery capital (Mawson et al., 2015), something that is especially important for the participants in the current study, to counteract the isolation and the loneliness, characteristics that are so prevalent among older problematic drinkers (Canham et al., 2016; Ingram et al., 2020; Pettigrew, & Roberts, 2008). Kate, for instance, has recognised the importance and benefits of being and connecting in the community. When Kate lost her job as an engineer, she lost her identity too, which had given her life a purpose and meaning, she was left with an existential vacuum. Her newly constructed community connections are one of the many components of the available social capital that have helped to fill that void.

> *I recognise now the importance of community and connection. And it is that meaning and purpose that I'm seeking in my older age …*
>
> *I now realise that my priorities are my family, my friends and connections, you know, community connections. You know, if I can help with anything I do, you know, I help old ladies go to hospital and appointments and stuff like that now. But also, my just volunteering at the charity shop.*

> *So, my meaning and purpose is like, pretty good these days, even though I'm not doing a great deal.* (**Kate**)

As well as the peer-based recovery support that mutual-aid groups provide, the individual in recovery is presented with the opportunity to connect, or in many cases, re-connect socially with other human beings. This fundamental social function of 'being with others', is often interpreted purely in terms of helping a fellow sufferer and thereby reinforcing one's own sobriety and recovery, which of course it is, while the pragmatism of building social networks is often overlooked. Working with the Alcohol Care Team, in a voluntary capacity at King's College Hospital, Terry visits patients who have alcohol and other drug problems; he has an almost poetic way of relating his experiences.

> *Just that the idea that each of us is on their own journey. And you know, when we do the hospital service, for example, we go in and we speak to people and we've got maybe twenty minutes with them, maybe half an hour, if you're lucky, and then you never see them again. In that, in that brief time you connect, you listen to them, you impart some of your own experience and then that's it you go your separate ways.*
>
> *I spoke to this guy for about an hour, he was speaking too, he was really. He'd never heard about A.A. or any other type of recovery or anything like that, he was all ears.*
>
> *That idea is now in that gentleman's head, If he doesn't pick up the first drink, he can't get drunk. […] I don't know where he is now, but that idea has become part of his journey.* (**Terry**)

Similarly, Audrey has used her lived experience of problematic drinking as a means of accessing social capital. Audrey credits Turning Point as the organisation where she found recovery. Although Turning Point does not default to a 12-step recovery paradigm, they do recognise the importance and value of the twin constructs of peer-based recovery support and

sharing a common lived experience of problematic drinking. Audrey's husband too, is supportive and involved in her recovery.

> *Uhm, and those were much more practical, they weren't 12-step at all, and really the, the intention was you had to come in four days a week for 12 weeks, and a lot of people were there because of what do you call them (?) uh, community something orders. […] that was a really interesting, that was a very interesting experience because, uhm, they, you know, they're, they're people who were motivated to be there because they wanted to get their kids back. They wanted to keep their housing. They needed to, you know, they, they needed support in the community, to get their lives back on track. […] So, quite different from the residential experiences I had, which sometimes felt a little bit like summer camp.* (**Audrey**)

Re-connecting socially is particularly important for Claire, a life-long social worker. Claire credits her local drug and alcohol services (Acorn) with her initial recovery. She is critical of her experiences with A.A. However, and perhaps because of her background as a social worker, she does recognise the value of A.A. as social capital.

> *... the language that they used was really poor, really stigmatising. […] And the person running the group says, "well I know who you are, you're just an old alkie". […] I found it predatory, I found it hierarchical. I found people treated people with derision. I found relationships were blurred, at best and abuse at times. I found people manipulative.*
>
> *... it was ... it wasn't all bad, because it did fulfil a need, in terms of people, yeah(?), which is crucial, crucial, for somebody like me, ehm, and it gave me something to do.*
>
> (**Claire**)

<u>Conclusion to Late-onset Theme 2</u>

The theme highlighted the importance and value of social capital in recovery. Additionally, the theme emphasises that peer-based recovery support and the mutual-aid model is not solely

about support through the reciprocation of shared lived experiences, which of course is its primary function; peer-based recovery support also supports the individual in recovery to access social networks.

5.3.5.3 Late-onset Theme 3.

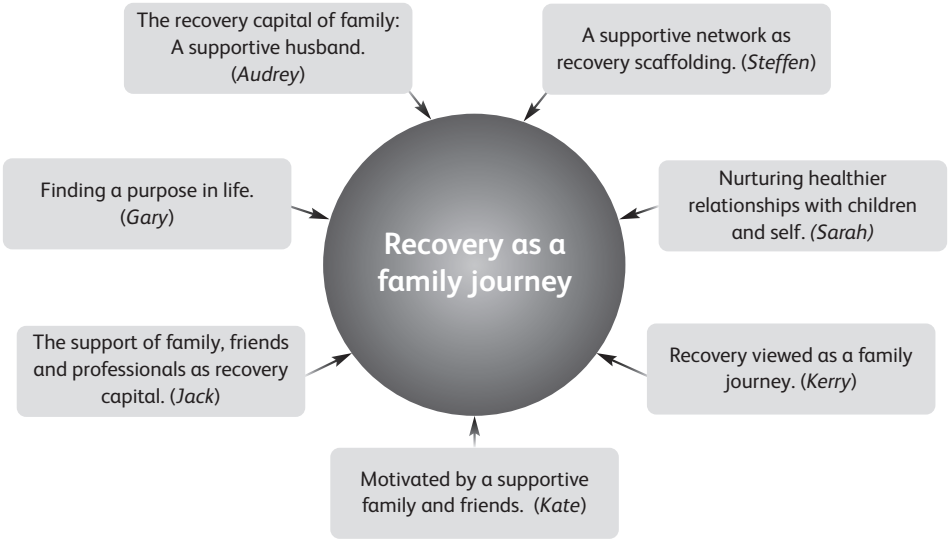


Figure 5.9. *Late-onset group experiential theme 3 and constituent personal experiential themes.*

In common with the early-onset cohort, one of the late-onset group experiential themes is framed within the context of the family in recovery, however, that is where the similarity ends. In contrast to the dynamics of the early-onset group, negative and often hostile, the family dynamics in the late-onset cohort are positive and supportive. Steffen, for example, is certain that, if he had been left on his own after he came out of detox, he would have relapsed, but his ex-wife and her partner, became the scaffolding that supported his early recovery.

> *And so, she and her partner, you know her boyfriend, were living together and they, you know, they opened-up their house to me after I left the detox and I was waiting to go to a particular, you know, inpatient programme. [...] you know, it took three weeks before I was able to go to one after I left detox, you know, and three weeks is a really long time when you're in early recovery, right? I mean, every day is in an eternity. So, it was really helpful that I was able to stay with her during that time, to stay with them*

> *and, and …. because otherwise, I think I would have relapsed, you know, and started drinking again.* (**Steffen**)

Sarah had a history of relapsing and there were times, when her children were teenagers that the parent/child roles were reversed. Nonetheless, her children have been deeply affected by her drinking. Sarah's narrative about her relationship with her daughter being a contributory factor in her drinking, shows that she still has some way to go in her recovery. Nonetheless, Sarah's children have been extremely supportive in her recovery.

> *I was encouraged and supported through my last couple of relapses. They took me to rehabs. They were the adults, and I was the child, and we had several meetings around that. […] I would say that they're supportive in terms of things, like they say "We're really proud of you, you're changing, you seem different, you don't seem so anxious. We're not so worried about you". They had distanced themselves from me, and I had to look … I've had to develop a completely new relationship with my daughter. We had to develop a new relationship because, I didn't believe it, we were, had a very inter-dependent relationship. So, I suppose she is supportive in terms of, in terms of … she also knows that our relationship didn't help my drinking.* (**Sarah**)

Kerry's family relationships suffered when she was drinking, but she doesn't dwell on her drinking self. Having suffered because of Kerry's drinking, her son and husband have been supportive. However, similarly to Sarah, her relationship with her daughter is fragile and fractious, but a new relationship is emerging. What emerges from Kerry's narrative, and Sarah's also, is that recovery is often a shared journey.

> *… my daughter couldn't wait to leave home. Ehm, I was a house drinker, you know. Ehm, it really got in the way of nearly everything. The three of them got all my stuff I was just content to sit and drink, you know. Ehm, but then again, it's, it's, it has improved a lot now, it's not perfect.*

> *My husband and my son are very supportive. My daughter is getting married in May. She's bought a house with her fiancé. Ehm, that relationship is going to take a long time. Ehm, and there's no point in going back and try and recapture the teenage years. It's like building a new relationship. I'm not hankering back to, what I should have done when she was a teenager. Ehm, it's a relationship with two adult women who just happen to be mother and daughter […] So, I'm building on that rather than keeping harping back to, you know, my drinking days. But it's working, it is working.* (**Kerry**)

Gary's daughter had a life-limiting illness and died when she was just eight years-old. Gary's other children, he has twins, were affected by his drinking, *"Oh he's drunk, he's sleeping in bed"*. He is aware of the psychological damage his problem drinking caused, so not surprisingly, family is his primary purpose in life.

> *... I've got a family, a wife, two kids who are doing pretty well at school, nice house, so my sort of, my purpose is to kind of try and lock that in a bit a bit more reliably, so that I can, I can then inch forwards with getting a job and, and ehm, being out of the house or doing a lot more work where I won't upset the apple cart of where we are now.*
>
> *I can only do that from the stable base of, of, you know, family life that, that I feel is on track, which is almost there but not, you know, not quite there.*
>
> *Whereas I was on the path of, you know, unhappy children, divorce, you know, selling the house, all that kind of stuff, when, when I was overdoing it, if you like.* (**Gary**)

Conclusion to Late-onset Theme 3

The third late-onset theme suggests that for the late-onset participants in the current study, recovery is framed within the context of a positive and supportive family; as such recovery, invariably, is not so much an individual experience, rather it is a family journey. In contrast, the family dynamics of the early-onset group in recovery were, at best, indifferent, reflecting

similar differences in family dynamics between the groups when they were drinking problematically.

5.3.5.4 Late-onset Theme 4.

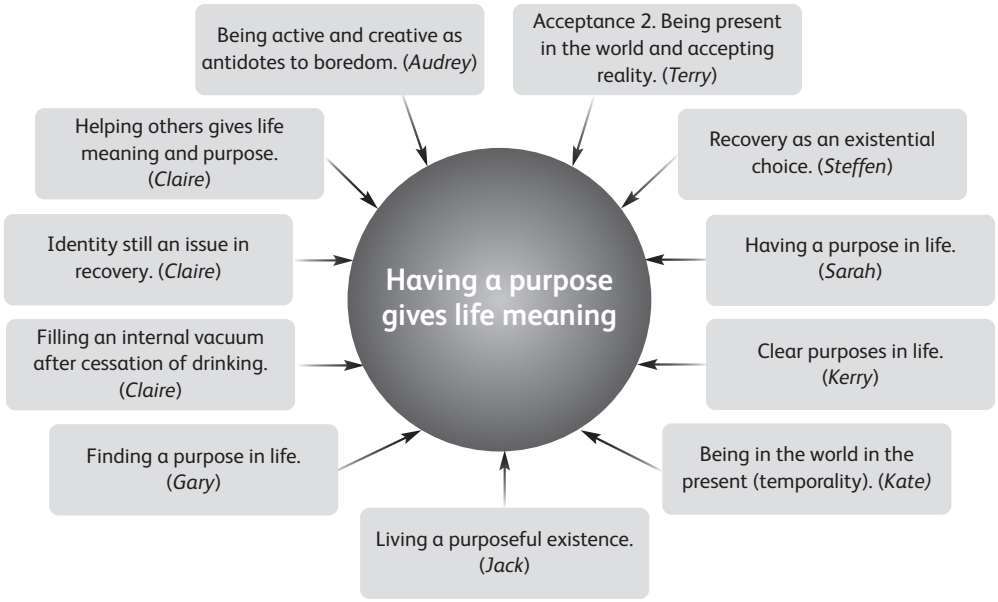


Figure 5.10 *Late-onset group experiential theme 4 and constituent personal experiential themes.*

The final late-onset theme reflects the last early-onset theme. Both themes highlight that re-discovering meaning, through having a purpose in life, is viewed an essential component of recovery (e.g., Best, 2019; Cloud & Granfield, 2001; United Nations Office on Drugs and Crime [UNODC], 2008; WHO, 2020). However, the route the participants in each group have taken in their search for purpose in life and consequential meaning, are divergent. Whereas the early-onset cohort have found a purpose in life, mostly in supporting others in recovery, the sources of purpose and meaning, for the late-onset group are more varied. Claire is a pragmatist, and her narrative in the context of finding MPL, as well as being Franklian, is a pragmatic language.

> *... and all the behaviours were around those kinds of things, so oh, you know, if we go somewhere, can we get a drink? If it ... you know that kind of thing. So having taken*

> *that away, there was a huge gap, vacuum. So, it was then, it was then a matter of trying to fill the time with ehm … other things.*
>
> *… some of my purpose in … I'm a social worker, I'm a helper, you get help from me, sometimes, even if you don't want it, you know, unless I'm careful. So, there is something around giving back. Something about, you know, keeping myself on the right course. Which for me is about treating people properly and being treated properly.*
>
> *It's more, it's more about being human, really. I think, to me, it's giving something of yourself away that clearly you should be, within yourself. So, much more to do with being human than anything else.* (**Claire**)

In the introduction to this study, Steffen referenced the SAMHSA (2012) definition to define his recovery. Steffen's initial purpose in recovery was the ultimate existential dilemma.

> *… you know, I finally, you know, sort of had, knew I had the choice of like, well, I could die or I could live […] And for me personally, I knew, like, it wasn't just alcohol was the problem, you know? I knew it was more than that.*

Receiving a diagnosis of ADHD in recovery, when he was in his sixties, and being prescribed the correct medication, obviously, gave added meaning to Steffen's life.

> *I took the Adderall, it was like, wow, you know, I'm sitting here, I'm thinking and I'm writing an e-mail and I'm thinking about the e-mail and, and I'm feeling better, and boy, that's it, you know, that's really cool, you know?* (**Steffen**)

Jack seems reluctant to admit to having an aim or purpose in life, which he views as being contrary to his philosophy of taking *"each day as it comes"*, which conversely can be interpreted as purpose enough. That said, Jack has a multitude of *"practical"* purposes, most of which are socially orientated, which, perhaps unconsciously, counteract the deeply embedded isolating behaviours associated with his problematic drinking.

> *I went back to the college to teach and people […] So yes, it was people encouraged me to do activities and stuff like that after the cold-turkey had kicked in, made it easy for me not to worry about cravings, not to see the solution to problems as being in a bottle, but to get that fresh air and to make contact with people I hadn't seen for a long time and to doing the thing.*
>
> *But coffee shops, I didn't know existed. I didn't know you could go into a coffee shop with a friend, order a cup of coffee, sit with it for an hour.*
>
> *Ehm, was Saturday afternoons were proving difficult, Saturdays are proving difficult after I sobered up and all that kind of stuff, that's a long day. And I knew one or two people who went to Partick Thistle on a Saturday afternoon and I contacted them and I said, "Can I come down to the games with you?"* **(Jack)**

In common with Jack, Kerry's purposes in life are simple and pragmatic. They reflect a simple philosophy in recovery, to behave like a decent human being and be treated in a reciprocal way by others. Kerry too, is slowly discovering that drinking wasn't the problem. Trying to live this way means that Kerry is now *"most of the time"* anyway, *"in a wee happy bubble"*. Asked about her purpose in life, Kerry responded that it was to be authentic, to be *"a whole person"*.

> *I was a dry drunk for over a year. I made the assumption that, I made, I sort of made the assumption that if I stopped drinking, everything would get better, that drinking was the problem.*
>
> *... somebody asked me one day there, like, what was my purpose in life, and they said, "don't use the twelfth step of AA you know, which is the, you know, maintain your sobriety and …. And I, and I thought about it, It was that sort of integrity to ... for the outside, to match my outside to match my inside so that I am (pause) like a whole person for the first time ever, you know. Like I do, I do get cross. I do get, ehm …. I don't let people walk over me or that sort of thing, but I don't create havoc anymore and I think*

> *that's my, ehm … I think that's my purpose in life, you know, to wear it lightly, just not trample over people or anything like that there.* (**Kerry**)

Conclusion to Late-onset Theme 4

The participants in the current study, early- and late-onset, have found that having a purpose in life, is an essential component to their recoveries. The theme suggests that, from having a purpose in life, meaning emerges to fill the vacuum, referred to by Claire above, which was once filled by alcohol.

5.4 DISCUSSION

Definitions of recovery were discussed earlier in the chapter, where it was noted that recovery is a fluid concept, holding different meanings, dependent on the perspective of the various stakeholders (Witkiewitz et al., 2020). Analysis of the narratives in the present study agrees with that position, finding that the concept of recovery among the study's 18 participants, was understood from an individual perspective. From the group perspective of early- and late-onset problematic drinkers, there were, of course, differences between the two cohorts; however, there were many points of convergence too. Moreover, it was reported earlier in the text, that concepts of recovery presented by members of mutual-aid groups, tend to be influenced by the organisation to which the individual was affiliated (Glassman et al., 2022a; Williams, 2021); this was evident in the discourses of the A.A. participants in the study, who not surprisingly, frame their recoveries within an A.A. 12-step philosophy. The present study identified several common group themes across the study's two cohorts (five early- and four late-onset). To address the study's research questions, presented earlier (see p. 157), the nine themes have been further reduced and can be explained within the confines of four domains: *abstinence self-efficacy*, *family*, *social recovery capital*, and *MPL*. These four domains are discussed further, highlighting points of convergence and divergence, between the two cohorts being highlighted.

Abstinence self-efficacy

The high degree of personal resources, that emerged from the narratives of both cohorts, meant they shared a common theme: *Abstinence self-efficacy: a primary mechanism of behaviour change*, 14 of the study's 18 participants, for instance, had PETs that mapped onto that one theme. Most of the participants across both groups had received some form of therapy or treatment. In that context abstinence self-efficacy is known to promote positive changes in pre-treatment drinking behaviour (e.g., Noyes et al., 2018; Stasiewicz et al., 2013), increase during treatment, regardless of mental health co-morbidities (Greenfield et al., 2012; O'Hare, & Shen, 2015; Stein et al., 2012; Warren et al., 2007), and importantly, in the context of the current study, affect post-treatment outcomes significantly (Crouch et al., 2015; Ilgen et al., 2005, 2006, 2007, Maisto et al., 2015; Moos, & Moos, 2006). Furthermore, an integrative data analysis of abstinence self-efficacy in four clinical trials (Kruger at al., 2021) found that evidence-based treatments were associated with significant increases in abstinence self-efficacy following treatment, compared to community treatments that focussed purely on counselling and 12-step programmes, who were less likely to promote abstinence self-efficacy. The four evidence-based treatments cited by (Kruger et al.,2021) included a total sample of 3,720. The studies included were, the Project MATCH aftercare sample (n = 774) and the Project MATCH outpatient sample (n = 952; [Project MATCH research Group, 1997]); the COMBINE study (n = 1383 [COMBINE Study Group, 2003]), and two telephone continuing care studies (Tel 1, n = 359 [McKay et al., 2005]; Tel 2, n = 252; [McKay et al., 2011]).

However, the participants' narratives shows that the initial source that encouraged the abstinence self-efficacy in both groups, was peer-based recovery support. The first peer-based recovery support early-onset theme, *Mutual-aid and peer support nurturing recovery*, suggested that peer-based recovery support as a source of abstinence self-efficacy was more prevalent among the early-onset participants, compared to their late-onset counterparts. The

first peer-based recovery support early-onset theme, *Mutual-aid and peer support nurturing recovery*, suggested that peer-based recovery support as a source of abstinence self-efficacy was more prevalent among the early-onset participants, compared to their late-onset counterparts. This is an important finding, and the explanation may be that peer-based recovery support also formed the basis of a social network for the early early-onset participants, who, on the whole, had far less family support, than the late-onset participants, who had more family support and better social networks. These findings support both self-efficacy theory (Bandura, 1977) and social learning theory (Bandura, & Walters, 1977).

Bandura's (1977) seminal theory proposes that levels of self-efficacy are determined by an individual's expectations (self-belief). That is, the degree to which they can assert change on a given behaviour; in the current context, drinking behaviour. According to Bandura (1977), expectations of self-efficacy, are informed and emerge from four primary sources: performance accomplishments, vicarious experience, verbal persuasion and physiological states" (p. 194); all these sources are abundantly present in the narratives of the participants in both cohorts. Further, a broad body of work has highlighted the positive association between peer-based recovery support and abstinence self-efficacy (Tracey, & Wallace, 2016; van Melick et al., 2013), including in a criminal justice system context (Majer et al., 2015, 2016; Marlow et al., 2015; Whipple et al., 2015). Additionally, because of their shared experiences of the adverse consequences of harmful levels of alcohol consumption, all the participants have chosen an abstinence-based pathway of recovery.

The family in recovery

The family is an important component of the social recovery capital model of recovery, conceptualised by White and Cloud (2008). It is an axiom that the behaviour of individuals who drink problematically and their families, are "inextricably bound" (McCrady, & Flanagan, p. 2, 2021), both during active drinking and sobriety/recovery. In acknowledging the

inseparable and dynamic complexity of family relationships, the RC model recognises family as a core component of recovery (e.g., Best et al., 2021b; Cano et al., 2017; UNODC, 2008). That said, the participants' narratives highlight notable differences in family relationships between the two cohorts in recovery, evident in the titles of their respective themes (and constituent personal experiential themes): *Accepting and managing dynamics in recovery* (early-onset), *Recovery as a family journey* (late-onset). Some of the participants in the early-onset cohort, for instance, faced family hostility and negativity (e.g., Heather), while others have had to negotiate and manage the scars of growing up in a family drinking culture (e.g., Mike); for these participants, recovery in the context of family functioning, was challenging, and not a case of "happily ever after" (Schmid, & Brown, p. 31, 2008). The narratives of these participants suggests that their high levels of abstinence self-efficacy were not nurtured within a positive and supportive family setting and were more likely encouraged vicariously via peer-based recovery support, as well as previously performed accomplishments and improved emotional regulation (Bandura, 1982).

From a family perspective, compared to the early-onset group, as the title of their family-related theme suggests, recovery for the late-onset cohort from a family perspective, was mostly viewed as a shared experience between the recovering problem drinker and their family members. Moreover, their families, tended to be more supportive and have improved family functioning in recovery; supportive family and friends, as well as peer-based recovery support, are also known to promote abstinence self-efficacy (Bradshaw et al., 2015; Tracey, & Wallace, 2016; van Melick et al., 2013). Edwards et al. (2018) found that family members of individuals in recovery were on their own recovery journeys; this was the case for some of the family members of the late-onset cohort in the current study (e.g., Sarah's children). The broad body of work on older problem drinkers may explain the disparity in family support and functioning between the two groups of older problem drinkers. Firstly, late-onset problem

drinkers are likely to have lived in a more functional family environment, compared to people with early-onset AUD/problem drinking (Liberto and Oslin, 1995; Wetterling et al., 2003). Moreover, it has been suggested that family pressure and support is a major factor in the decision of late-onset problem drinkers to stop drinking and enter treatment (Emiliussen et al., 2017a, 2017b, 2017c, 2019). Older, late-onset problem drinkers are also less likely to relapse after treatment (Moos et al., 1990). Additionally, early-onset problem drinkers are more likely to have been associated with, and affected by a family drinking culture, compared to late-onset problem drinkers (Atkinson et al., 1985, 1990; Finlayson et al., 1988; Wetterling et al., 2003), similar to the two groups in the current study. While on the context of the family in relation to recovery, Stelle, & Scott (2007) have suggested that older drinkers might benefit from family orientated interventions.

Social recovery capital

The social recovery capital model of recovery (White, & Cloud, 2008) has more recently been defined as the "opportunities and benefits associated with social group memberships and family relationships" (Mawson et al., p. 2, 2017) Broadly speaking, social recovery capital includes the intellectual, material, psychological and emotional resources (this is not an exhaustive list), within family and social contexts, that are available and accessible to the individual, that can be utilised to support them in their recovery journey. Having already considered the family component, the discussion focusses on the social aspect of the social recovery capital model, of which peer-based recovery support is a central component (e.g., Andreas et al., 2010; Best et al., 2012; Boisvert, 2008). In the context of abstinence self-efficacy, the current discussion has already had much to say about the social model type role that mutual-aid-orientated peer-based recovery support plays in encouraging this important and liberating construct (e.g., Majer et al., 2015, 2016; Marlow et al., 2015; Tracey, & Wallace, 2016; van Melick et al., 2013; Whipple et al., 2015). However, positive and healthy social networks should not be restricted

solely to mutual-aid circles, and may include, "religious/spiritual groups; workplace networks, and social clubs/activities" (Boeri et al., 2016), which is the case for many of the participants in the current paper (e.g., Kate, late-onset, p. 178).

However, older adults are, invariably, associated with waning social networks (Theeke, 2009). Moreover, older problem drinkers are less likely to engage socially and have positive and supportive social networks (Hanson, 1994). Emerging from the psychological isolation associated with problem drinking (Boulze-Launay, & Rigaud, 2020; Canham et al., 2016; Ingram et al, 2020) and re-building efficacious social networks (Kiecolt, 1994) in recovery, was a common thread throughout the narratives of both groups, and suggested that, by far, the most important component in (re) connecting with society and building social networks was peer-based recovery support. Peer-based recovery support was slightly less prevalent among the late-onset participants, whose sober voices tended to describe recovery within a broader and more inclusive social framework, than their early-onset counterparts. For example, the late-onset cohort's social circles extended beyond the socially limiting boundaries of mutual-aid groups and peer-based recovery support (as suggested above), allowing them to engage with positive and community-based social networks and thereby, greater access to social recovery capital, something that has been strongly endorsed by Best and Hennessy (2022), leading researchers in the recovery field, and exponents of RC. Many of the participants in both cohorts had/have comorbid mental health problems, and it has been suggested that social factors, rather than medical interventions, are more likely to drive recovery from mental health problems (Tew, 2013).

Indeed, effective interventions have been developed within the wider contextual framework of social behaviour and social networks. For instance, Social Behaviour and Network Therapy (Copello et al., 2002; Copello et al., 2009) and the Community Reinforcement and Family Training (CRAFT) approach, developed originally by Sisson and

Azrin (1986). Social Behaviour and Network Therapy, for example is based on the simple concept that the best way for problem drinkers to affect behaviour change, and thus an effective recovery, is to foster positive social networks. Social Behaviour and Network Therapy, originally developed for use on problematic drinkers has been applied in the broader context of alcohol and other drugs (Coppelo et al., 2006), as well as being adapted for younger people with alcohol and other drug problems (Youth Social Behaviour and Network Therapy; Watson et al., 2017). Regarding gender differences within a social recovery capital context. There is some evidence to suggest that building and nurturing social networks is more likely to be associated with men as a mechanism of behaviour change, and that behaviour change in women is primarily associated with improvements in abstinence self-efficacy (Kelly, & Hoeppner, 2013). That women may be less likely to foster positive social networks in recovery, could be associated, in part, to the greater perceived social stigmatisation they experienced, when they were drinking problematically (Fortney et al., 2004; Brennan et al., 1993). There were, however, no noticeable gender differences within a social context in the present study.

Having a purpose and finding meaning in life

The thesis' accompanying literature review highlighted a dearth of reporting on MPL in the context of late-onset problem drinking, with only two of the reviewed papers reporting explicitly, and a further four implicitly. Moreover, the data for these papers was harvested from late-onset problematic drinkers who were either still drinking (Christie et al., 2013; Finlayson et al., 1988; Van Montfoort-De Rave et al., 2017) in treatment (Adams, & Waskel, 1991a; Wadd et al., 2011) or in very early recovery (Emiliussen et al., 2017c). In contrast, most of the participants in the current study are in stable or long-term recovery; length of time in recovery is associated with greater MPL (Junior, 2006). It is not surprising, therefore, that having a purpose and finding meaning was noticeably more prominent in the recovery voices of the participants in both cohorts, compared to their retrospective narratives, when they were

drinking. Similarly, in the wider generic context of problematic drinking, researchers suggest that individuals with AUD/problem drinking lack purpose and meaning in their lives (Chapman, 1996; Katsogianni & Kleftaras, 2015), and recommend that having a purpose and finding meaning in life is central to achieving and maintaining recovery (e.g., Laudet, 2007; Laudet et al., 2006; UNODC, 2008; White et al., 2006; WHO, 2020). However, this change in attitude and way of thinking does not emerge in a vacuum. Such transformations are the consequence of the complex interactions of the closely entwined themes and domains identified in the present study.

The personal themes that constitute the fifth early-onset theme (*Empathy: reaching out to others gives life meaning*) and the fourth late-onset theme (*Having a purpose gives life meaning*), for instance, show how the participants in both cohorts have developed a purpose in life and, consequentially, found meaning in their lives. This has been achieved more generally by helping others (not just other individuals in recovery), re-building family connections (late-onset), or, alternatively, accepting dysfunctional family dynamics (early-onset), re-connecting and engaging with society, re-constructing identities and re-building self-worth through self-belief (abstinence self-efficacy). All of which, have ultimately given, or at least contributed, to giving the participants' lives a sense of meaning. These examples suggest that MPL is mediated by the other three domains, *abstinence self-efficacy*, *family* and *social recovery capital*. Moreover, from a social perspective, and within the context of the age range of the participants in the present study, there is a relationship between being socially active and having a meaningful life. Data from a large sample of 7,304 men and women of 50-years-old or older (m = 67.2 years) showed that greater social engagement was associated with having a more worthwhile and meaningful life, both physically and mentally (Steptoe, & Fancourt, 2019).

Poor mental health, particularly depression (Bilevicius et al., 2021; Mowbray et al., 2017), anxiety (Buckner et al., 2008, 2013; Thomas et al., 2008) and emotional dysregulation

(Jakubczyk et al., 2018; Khosravani et al., 2017, 2018; Mason, 2017), are prominent features in the discourses of active problem drinkers. The narratives of the participants of both cohorts in the present study show that emotional dysregulation and poor mental health improved greatly in recovery (e.g., early-onset theme three: *Finding psychological and emotional equilibrium*). That improvements in emotional and mental health are in concert with recovery, suggests that problematic drinking and poor emotional and mental health are, most likely, mutually supportive. Moreover, a sense of purpose and having meaning in life play a considerable and effective role in improvements in psychological and emotional health. Meaning making for example, mediates anxiety and depression (Marco et al., 2020; Radicic, & Rivardo, 2019), hopelessness (Wnuk, 2022), suicidal ideation (Sun et al., 2020), and self-esteem and quality of life (Kim, & Choi, 2021), while having a sense of purpose is associated with nurturing resilience against higher depressive symptoms and memory deficits in older adults (Lewis, & Hill, 2021).

5.4.1 Summary of findings

Points of convergence between the groups

- All participants follow abstinence-based recovery pathways.
- High levels of abstinence self-efficacy was prevalent in both cohorts, vicariously reinforced by social models, in the form of peer-based recovery support.
- The study suggests that reaching out and helping others (empathy), mediates and promotes abstinence self-efficacy.
- Having a purpose in life, and finding meaning was an important component in maintaining recovery and was equally prevalent in both groups.

Points of divergence between the groups

- eer-based recovery support and mutual-aid organisations were important social recovery capital for both cohorts in early recovery but were slightly more prevalent among the early-onset cohort, compared to the late-onset group, who had developed broader social recovery capital networks, separate from the peer-based recovery support/mutual-aid model of support.
- The families of the late-onset cohort were supportive of the participants' recoveries, compared to the families of the early-onset participants, who tended to be more ambivalent about recovery.
- Both groups experienced considerable improvements to their psychological, emotional and mental health in recovery. However, the early-onset cohort were slightly more likely to face challenges in these domains than the late-onset group.

5.4.2 Concluding remarks and implications

The heterogeneity of the mutual-aid recovery pathways (refer to Tables 4.1 and 4.2, p. 118) found by the participants at the beginning of their recovery journeys, was reflected in the diversity of their unique recovery voices. That their individual discourses had varied origins, contributed to the richness of the data, and reduced the possibility of the data being biased by a single source (e.g., A.A.). This of itself is an important finding, highlighting a healthy choice of the multiple recovery pathways that are now available to older problematic drinkers seeking help. The earlier literature review had shown that older adults were less likely to seek help

(Brennan, & Moos, 1991), particularly women (Brennan et al., 1993) and older adults from black and ethnic minorities (Wadd et al., 2011), due in part, to the stigmatisation associated with problematic alcohol use (Emiliussen et al., 2017b).

Some of the late-onset participants (and to a lesser degree, participants in the early-onset group) had been scathing about their A.A. experiences, and it is worth considering whether they would have found recovery, if A.A. had still been the 'only show in town', as it had been for so long. It should, therefore, always be an important consideration for health-care professionals treating late-onset drinkers, indeed all problem drinkers, that the same recovery pathway will not always be suitable for the diversity of personality types they are likely to encounter, who are likely to have uniquely individual requirements (Glatt, 1991). Furthermore, late-onset problematic drinkers are known to have positive outcomes, provided they are matched to the appropriate treatment programmes (e.g., Dauber, 2018; van den Berg et al., 2014), supported by RC and social recovery capital (Emiliussen et al., 2017 a, 2017b, 2017c).

Regardless of the differences in the participants' recovery pathways, compared to their (retrospective) drinking narratives, there was far more convergence between the recovery voices of the two cohorts, evident in the four recovery domains discussed above. Nowhere was this more evident than in the high levels of perceived abstinence self-efficacy. Self-efficacy hypothesises that the individual's expectation of a given action or behaviour will lead to a particular outcome, and "An efficacy expectation is the conviction that one can successfully execute the behaviour required to produce the outcomes" (Bandura, 1977, p.193). However, it was clear in the participants' voices, that the three other domains, *Family*, *social recovery capital* and *having a purpose in life and finding meaning* included in the discussion above, are the scaffolding that support and promote abstinence self-efficacy. In summary, the current study found a high degree of convergence in the psychosocial characteristics and recovery pathways between early- and late-onset problem drinkers. The current study also found that the

role that having a purpose in life and finding meaning plays in the context of maintaining recovery, is a positive, social and existential one. The role these extremely important dimensions play in recovery are investigated further in the remainder of this thesis.

Chapter endnotes

1. Linguistically, the current thesis aimed to use a less stigmatising, softer and more inclusive language in the context of problematic drinking. However, when citing older papers, it is often difficult to avoid using terminology that nowadays would be considered by many as stigmatising and inappropriate, e.g., alcoholism.
2. Appendix 5.0, 'Glatt's Chart and Jellinek's Phases', presents a history of the origins and creation of this landmark concept, including graphic representations of Jellinek's Phases and Glatt's Chart (AKA Jellinek's Curve).
3. The data in the *UK Life in Recovery Survey 2015* (Best et al., 2015) were gathered from a broad spectrum of addictions, with alcohol being just one of them.

CHAPTER SIX

HAVING A PURPOSE AND FINDING MEANING IN LIFE

"Addiction too is at least partially to be traced back to the feeling of meaningless."
(Frankl, 2011, p. 26)

6.1 INTRODUCTION

Using a qualitative method (IPA), the two previous chapters investigated the psychosocial characteristics and recovery pathways of early- and late-onset problem drinkers and the role of MPL in relation to both groups when they were actively drinking and when in recovery. Analysis of the participants' discourses in those chapters showed that there was a lack of MPL in both cohorts when they were actively drinking, whereas it was found to be an important construct in both groups in recovery. The objective of the current chapter is to further investigate the role of MPL in both groups in recovery, as well as their psychosocial characteristics and recovery pathways, but from a quantitative perspective. At this point, it will be useful to reiterate the thesis' theoretical framework, based on Frankl's theory of meaning: logotherapy.

Frankl (1963) proposed that the search to find meaning in one's life is the primary human motivational drive, and that without this vital instinct people are prone to experience "a lack of content and purpose" in their lives (Frankl, 2014 p. 61), equivalent to a psychological and spiritual feeling of emptiness. In accordance with Frankl's logotherapy, the current thesis advances the notion that due to major, adverse events that can often occur later in life, e.g., pain and social isolation, some older adults and people in middle-age, experience an *existential vacuum*, which manifests as boredom and apathy. To cope with this empty feeling, some of them (late-onset) use alcohol to self-medicate and begin to drink alcohol excessively and problematically (Emiliussen et al., 2017a, 2017b, 2017c; Wadd, & Galvani, 2014, Wadd & Papadopoulos, 2014; Wetterling et al., 2003). Drinking alcohol to excess to cope with a lack

of MPL is not exclusive to late-onset problem drinkers and can also apply to drinkers in a general context (e.g., Copeland et al., 2020; Cranford et al., 2014; Lyons et al., 2010; Marsh et al., 2003; Roos et al., 2015; Waisberg, & Porter, 1994), drinkers with depressive symptomologies (Kleftaras, & Katsogianni, 2012) and relapsers (Sliedrecht et al., 2022).

In contrast to the negative effects associated with a lack of MPL, a considerable body of evidence highlights the positive physiological and psychological effects associated with having greater MPL, including improved health outcomes (Auhagen, 2000; Kang et al., 2019; Kim et al., 2020; Musich et al., 2018; Ryff & Singer, 1998), positive ageing (Gergen & Gergen, 2002; Mitchell & Helson, 2016), a lower mortality rate (Alimujiang et al., 2019; Cohen et al., 2016), and greater social engagement (Steptoe & Fancourt, 2019). Additionally, MPL is associated with a reduced risk of many chronic diseases and major health events that become increasingly more prevalent with advancing age, including cardiovascular disease (Cohen et al., 2016), dementia (Sutin et al., 2023) stroke (Kim et al., 2013), and a lower allostatic load[1] (Zilioli, et al., 2015). Allostatic load is "the price the body pays for being forced to adapt to adverse psychosocial or physical situations" (McEwan, 2013, pp. 110-111), similar to those encountered by the participants in the current study, when they were drinking problematically. Furthermore, there is an association between lower levels of the stress hormone cortisol, and positive psychological functioning (Lindfors & Lundberg, 2002); people who have purposeful and meaningful lives have healthier levels of cortisol (Pulopulos, & Kozusznik, 2018), and are less likely to develop stress-related health issues, compared to people with meaningless lives (Glazer et al., 2014). Moreover, MPL may play a role in regulating one's immune system, as well as some executive functions (e.g., self-efficacy) that promote health-related behaviours (Roepke et al., 2013). An overview of Franklian psychology, would be incomplete without considering a fundamental aspect of logotherapy, the spiritual dimension of human experience.

Frankl (1963) emphasised the spiritual nature of the existential vacuum concept, when he characterised it as a "psychic malaise" masking one's "spiritual struggles" (Frankl, 1969, p. 29). Although Frankl had a religious connectedness in his own life (Costello, 2015; Okan, & Ekşi, 2017), spirituality from a Franklian perspective should not be confused with religious constructions of spirituality, per se; spirituality in a Franklian context is an existential construct. Ontologically, both religion and logotherapy argue that a transcendental dimension is essential for a complete understanding of what it means to be human. Religion on the whole, explains spirituality from a dualistic perspective, i.e., a temporal biological being connected to a soul (a conceptual spiritual essence) that continues to exist when biological life ceases, thus, assuring the believer of continued existence and, ultimately, allaying the fear of death. Frankl's existential spirituality on the other hand, is concerned with how people experience life and find meaning and spiritual transcendence, wholly during their physical existence. Spirituality in a Franklian sense then, is about self-fulfilment, comparable to Maslow's (1958) notion of transcendence through self-actualisation: "the very highest and most inclusive or holistic levels of human consciousness" (Maslow, 1969, p. 66). Logotherapy asserts that everyone has the spiritual freedom, and responsibility, to find meaning in all their experiences, regardless of their circumstances (Das, 1998; Frankl, 1963, 1969; Yehuda et al., 2016). Frankl's spiritual framework is based on his lived experience as a prisoner in the Nazi concentrations camps in World War II, exemplified in one of logotherapy's major tenets, "that everything can be taken from a man but one thing: the last of the human freedoms — to choose one's attitude in any given set of circumstances, to choose one's own way" (Frankl's 1963, p. 75).

Another central feature of logotherapy, and one that is an extremely relevant and important consideration in the context of this thesis, is the aetiology of the existential vacuum. Described by Frankl (2011, p. 26) as "the mass neurotic triad comprising depression, aggression and addiction", with two of these symptoms, depression and addiction, often being

inseparable (e.g., Agabio et al., 2018; Heinsch et al., 2020; Lu et al., 2022). As discussed earlier in the text, depressive symptomologies (Kleftaras, & Katsogianni, 2012), and problematic drinking (e.g., Copeland et al., 2020; Cranford et al., 2014) are associated with a lack of MPL. In contrast, acquiring MPL is associated with recovery from problematic drinking (Cranford et al., 2014; Krentzman et al., 2015) and other substance use disorders (Lyons et al., 2010). Indeed, the potential benefits of MPL to people in recovery have been recognised by the WHO (2020) and UNODC (2008), who have stated that "Meaning and purpose in life is central to leading a full and healthy life." (p, 47). Consequentially, "(Re) discovering meaning and purpose in life", is listed as one of eight domains that constitute the RC framework of sustainable recovery management UNODC (2008, p. 17).

MPL, from a Franklian perspective then, is an attitude towards life that involves striving for spiritual connectedness, having goals, a sense of direction towards those goals, and a feeling that life (past and present) has meaning (Musich, et al., 2018). When considering the relationship between MPL and problematic drinking, it is important to bear in mind three fundamental tenets of logotherapy: 1) life has meaning, regardless of the circumstances, 2) the primary motivation in life is to find that meaning, and 3) people have the spiritual freedom and responsibility to find meaning in all they do. The objective of the current study is to further contribute to three of the thesis' research questions from a quantitative perspective: Firstly, *Investigate the psychosocial characteristics of late-onset AUD/problem drinkers in recovery and compare them with the psychosocial characteristics of early-onset AUD/problem drinkers in recovery*. Secondly, using two measures, the Purpose in Life test (Crumbaugh & Maholick, 1964) and the MLQ (Steger et al., 2006), *Explore and compare the role of MPL, between early- and late-onset problem drinkers, who are in recovery*, and finally, *Investigate and compare the recovery pathways of late-onset AUD/problem drinkers and early-onset AUD/problem drinkers*.

6.2. METHOD

Discussed in detail earlier (chapter three), this is a stand-alone, cross-sectional study, designed to investigate and compare the role of MPL, the psychosocial characteristics and the recovery pathways, of early- and late-onset problematic drinkers in recovery.

6.2.1 Participants and recruitment process

A representative, non-probability sampling method was used (also discussed in greater detail in chapter three). The participants, who responded to an online survey/questionnaire, were ex-problematic drinkers of ≥50-years-old, who were in recovery. To mitigate against recruitment biases, the study recruited participants from a broad and diverse population of people in recovery, using two methods of recruitment. Firstly, an introductory letter (*Appendix 3.4*) was sent (emailed) to several prominent recovery organisations (*Appendix 3.5*), and the drug and alcohol services of one NHS Trust: Surrey and Borders Partnership (SABP). The letter requested that the organisations direct people, who met the recruitment criteria, to an online questionnaire/survey. For this purpose, attached to the introductory email were an invitation to participate/information sheet (*Appendix 3.6*) and a recruitment poster (*Appendix 3.7*). The survey's url and a QR code that directed respondents directly to the online survey, were also included in the invitation.

The second method of recruitment was recovery-focussed Facebook groups. Potential groups were identified, by using suitable search terms in Facebook's search function, e.g., 'sober groups', 'groups in recovery from alcoholism', 'recovery from addiction'. A recruitment appeal was then posted on the Facebook page of each group deemed suitable (*Appendix 3.8b*). The appeal consisted of a headline, adapted from a relevant Carl Jung quote[2], aimed at drawing people's attention to the subject matter of the questionnaire/survey, followed by a brief summary of the research, and a link to the questionnaire/survey (*Appendix 3.8a*). Before being allowed to post on some of the groups, approval was required by the group's moderators. To

achieve a better response rate, each of the Facebook groups were re-visited regularly and the recruitment appeal was re-posted, meaning there was a greater probability of the post appearing at the top of the group's Facebook page.

6.2.2 Data collection and measures

Data were collected anonymously using an online questionnaire/survey, created in and hosted on the Qualtrics platform. Two measures, the Purpose in Life test (Crumbaugh & Maholick, 1964) and the MLQ (Steger et al., 2006) along with a demographic questionnaire were embedded in the survey. The Purpose in Life test is a 20-item measure on a seven-point Likert-scale (maximum score 140). The MLQ consists of ten questions on a seven-point Likert-scale divided into two subscales of five questions, one scale measures the 'presence' of meaning in life, while the other quantifies the 'search' for meaning in life; the maximum score for each subscale is 35. The authors of both measures do not recommend scores that constitute high or low purpose in life or MLQ, simply that higher scores suggest higher purpose in life or higher meaning in life. The beginning of the online questionnaire/survey included an explanation of the research, followed by an informed consent section. Before being allowed to continue and undertake the questionnaire/survey, respondents had to tick a consent to participate box (*Appendix 6.1*). Before collecting data proper, the measures were piloted on fifteen members of A.A. at the 2022 London International Convention. The raw data, were exported from Qualtrics into SPSS statistical software for analysis.

6.2.3 Strategy for treatment and analysis of data

A) *Defining age of onset*

The findings in the literature review approximated 50-years-old to be a cut-off age for late-onset problematic drinking. However, the review recommended that, *'a standardised cut-off age will be determined by the research undertaken in the main body of this thesis*'. This

recommendation was reiterated in chapter three, and again in chapter four, where it was stated that, '*the ages for the early- and late-onset participants investigated in the research undertaken in this thesis will be decided on the data collected during the quantitative phase of this thesis, specifically the question in the demographic questionnaire: What age do you think you were when your drinking became problematic?*' Before any descriptive and inferential statistical analysis could be undertaken, it was essential that the age categories for early- and late-onset problematic drinking were clearly defined. The cut-off age was determined by an investigation of the data relating to the respondents answer to the question in the demographic questionnaire mentioned above, and the sharp percentage rise in problem drinking after 45-years-old, which is explained in detail in the results section.

B) ***Answering the research questions and statistical tests used***

After analysing age categories and establishing approximate cut-off ages for early- and late-onset problematic drinking, further analysis was undertaken. All statistical analysis was carried out using SPSS software. To begin with, each of the respondents' sociodemographic characteristics (e.g., gender, sexual identity, relationship status) were analysed using descriptive statistics. Additionally, analysis of the relationship between each of the sociodemographic characteristics and onset-type (i.e., early- and late-onset) was undertaken. For the most part, the sociodemographic characteristic variables are categorical/nominal (e.g., gender, sexual identity), and chi-square statistics were performed on these. There was one ordinal variable in the sociodemographic section, 'continuous years in recovery', and to determine the relationship between this variable and onset-type, an independent-sample *t*-test was conducted. The statistical analyses undertaken in the sociodemographic section answer two of the study's three research questions. Firstly, *Investigate the psychosocial characteristics of late-onset AUD/problem drinkers in recovery and compare them with the psychosocial characteristics of early-onset AUD/problem drinkers in recovery*. Secondly, *Investigate and*

compare the recovery pathways of late-onset AUD/problem drinkers and early-onset AUD/problem drinkers.

T-tests, one-way ANOVAs and Pearson and Spearman correlations were undertaken to analyse data relating to the Purpose in Life test and the MLQ (presence & search). The same analytical tests were performed consistently across all three measures and their relationships with the sociodemographic variables. T-tests were performed to analyse the relationship between the three measures, and onset-type and gender. One-way ANOVAs were carried out to analyse and compare differences in the Purpose in Life test scores and the MLQ (presence & search), across the remaining categorical sociodemographic variables (i.e., organisations where recovery was found; sexual identity; relationship status; belief system; number of times in residential treatment). Pearson and Spearman rank correlations were performed to examine the relationship between the one ordinal variable, 'continuous years in recovery', in relation to the Purpose in Life test and the MLQ (presence & search). Finally, Pearson and Spearman rank correlations were carried out to examine the relationships between the three measures (i.e., Purpose in Life test, MLQ [presence] & MLQ [search]) These analyses answer the study's final research question, *Explore and compare the role of MPL, between late-onset AUD/problem drinkers in recovery, and early-onset AUD/problem drinkers in recovery*. Additionally, analysis of the measures and the sociodemographic variables addresses one of the thesis' four hypotheses (see chapter three): *that, regardless of onset-type, there is an association between the degree of MPL in individuals in recovery and their time in recovery*.

6.3. RESULTS

6.3.1 Categorising early- and late-onset problem drinkers

The ages of the participants and the age-ranges when they perceived that their drinking became problematic are shown in Table 6.1a and Table 6.1b respectively (on the following page). *Appendix 6.3* reports the individual ages of the participants.

Table 6.1a

Ages of the Respondents.

	Minimum	Maximum	Means	Std. Deviation
Total Sample	50	86	60.31	7.33
Early-Onset	50	86	60.16	7.58
Late-Onset	50	81	60.58	6.84

Table 6.1b

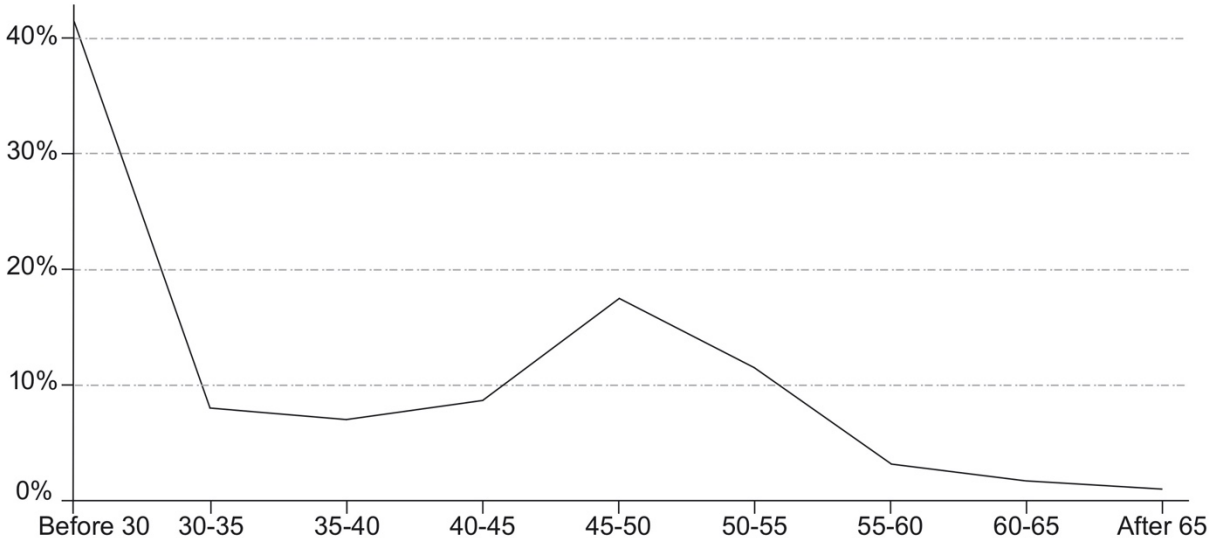
Participants' Perception when Drinking became Problematic by Five-year Age-ranges.

Age Range	Before 30	30-35	35-40	40-45	45-50	50-55	55-60	60-65	After 65	Totals
Frequency	158	31	28	32	62	49	12	6	3	381
Percent	41.5	7.9	7.3	8.7	16.3	12.9	3.1	1.6	0.7	100

The total number of individuals who fully answered the survey and who met the criteria was 381 (compared to an initial target of 128). Their ages ranged from 50 to 86-years-old (M = 60.31, SD 7.33). The question in the demographic questionnaire that asked the respondents when they perceived their drinking as becoming problematic, gave them nine options to choose from, ranging from before 30-years-old to after 65-years-old, with seven intermediate five-year age-range options (see table 6.1b, which shows the age-range distribution of perceived problematic drinking). The largest group of 158 respondents (41.5%) perceived that their drinking became problematic before the age of 30-years-old. After this group there was a drop of 33.6% to 7.9% (N = 31) for the next age-range group of 30-35-years-old, followed by 7.3% (N = 28) for the 35-40 age-range, and 8.7% (N = 32) for the 40-45 age-range. Figure 6.1a shows there was a marked increase in respondents between the 40-45 age-range (8.7%, N = 32) and the 45-50 age-range (16.3%, N = 62). This was followed by a 3.4% drop (N = 49) in the 50-55-years-old age-range, and then a rapid decline in responses in the three-remaining age-ranges: 55-60 (3.1%, N = 12); 60-65 (1.6%, N = 6); after 60 (0.7%, N = 3).

Figure 6.1a

Distribution of Age-ranges when Participants Perceived Drinking became Problematic.



It is a reasonable assumption that the age group who began drinking problematically before the age of 30-years-old (*N* = 158), can be categorised as early-onset problem drinkers. Further, it is also reasonable to assume that there will always be a degree of subjectivity when determining cut-off and onset ages for early-and late-onset problematic drinking; this is because there cannot be a sudden cut-off age, which can only be defined within an approximate age-range. Therefore, does the sharp percentile drop from the before 30-years-old age-range group (*N* = 41.5%) to the 30-35 age range group mean that the 30-35 (7.9%), 35-40 (7.3%) and 40-45 (8.7%) age groups, should be categorised as early- or late-onset? For the purposes of this study (and thus, the thesis), these age ranges, along with the before 30 age-range, are categorised as early-onset problematic drinkers, meaning that late-onset problem drinking is categorised as ≥45-years-old[3]. This decision is based on the sharp and definite rise from 8.7% in the 40-45 age-range group, to 16.3% in the 45-50 age-range group. Furthermore, that 84% of the late-onset participants perceived their drinking as becoming problematic between either 45-50-years-old (*N* = 62) and 50-55-years-old (*N* = 49), suggests that late-onset problem drinking most likely emerges between the ages of 45 and 55-years-old. Table 6.1c and Figures 6.1b, 6.1c (on the following page), summarise the categorisation of onset-types.

Table 6.1c

Categorisation of Early- and Late-Onset Participants by Age-range — Overall Sample Percentile.

	Onset-type									Totals
	Early-Onset				Late-Onset					
Age Range	Before 30	30-35	35-40	40-45	45-50	50-55	55-60	60-65	After 65	
Frequency	158	31	28	32	62	49	12	6	3	381
Percent	41.5	7.9	7.3	8.7	16.3	12.9	3.1	1.6	0.8	100.00

Figure 6.1b

Onset-type by Age-ranges — Within Group Percentiles.

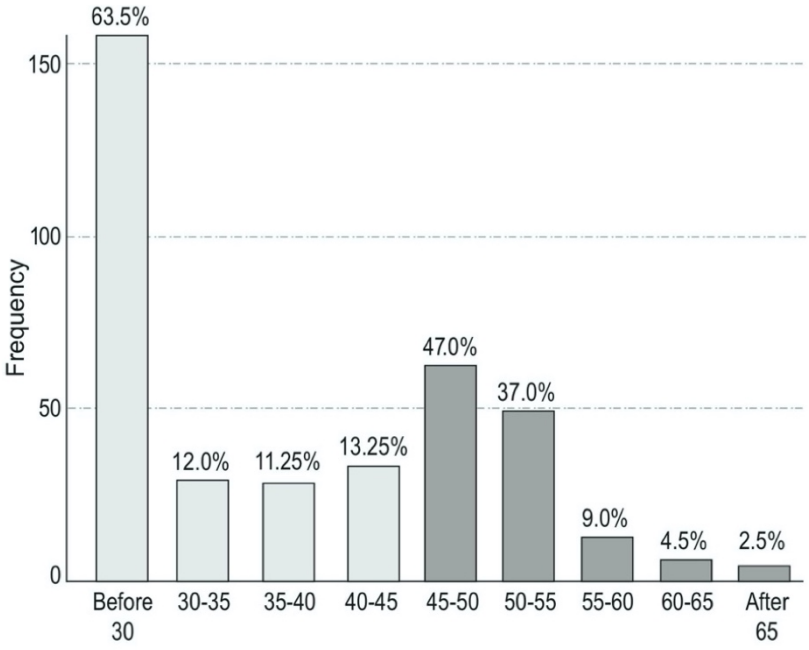
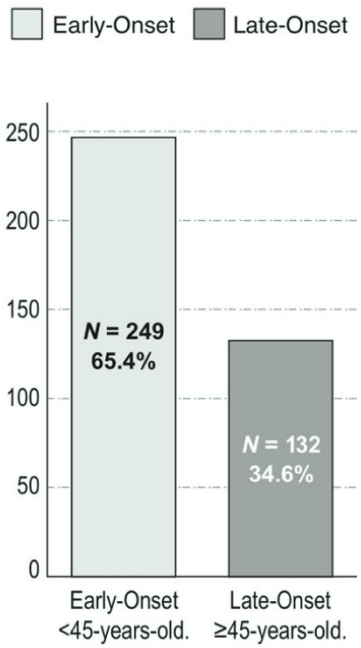


Figure 6.1c.

Categorisation of Onset-type



6.3.2 Sociodemographics

Table 6.2

Sociodemographics by Sample and Onset-type.

	Whole Sample		Early-Onset		Late-Onset		*p*-value[3]
	n	%[1]	*n*	%[2]	*n*	%[2]	
Gender							
Female	244	64.00	144	57.80	100	75.80	$p = <0.001$
Male	137	36.00	105	42.20	32	24.20	
Sexual Identity							
Heterosexual	343	90.00	223	91.70	120	90.00	
LGBTQ	20	5.25	13	4.50	7	5.30	$p = <0.001$
Prefer not to say	18	4.75	13	3.80	5	4.70	
Relationship Status							
Married/Cohabiting	218	57.20	130	51.80	88	67.40	
Divorced/Separated	95	24.90	66	26.50	29	22.00	$p = <0.731$
Widowed	17	4.50	13	5.20	4	3.00	
Single	51	13.40	40	16.50	11	7.60	
Number of times in Residential Treatment							
Once	65	17.10	39	15.70	26	19.70	$p = <0.15$
More than once	58	15.20	44	17.70	14	10.60	
Never	258	67.70	166	66.60	92	69.70	
Belief System[4]							
Religious	71	18.60	44	17.70	27	20.50	
Belief in a Concept of God but not Religious	130	34.00	92	36.90	39	28.80	—[4]
Secular/Spiritual	127	33.40	78	31.30	48	37.10	
No Spiritual Beliefs	53	14.00	35	14.10	18	13.60	
Organisation where the Respondents found Recovery[4]							$p = <0.001$ $p = <0.666$[4]
Alcoholics Anonymous	173	45.40	135	54.20	38	28.80	
SMART Recovery	17	4.50	10	4.00	7	5.30	
UK Community Drug and Alcohol Services (UK CDAS)	22	5.80	13	5.30	9	6.80	
NHS	13	3.40	7	2.80	6	4.50	$p = <0.001$
Other (various organisations)	92	24.10	46	18.50	46	34.80	
Self (Natural Recovery)	29	7.60	17	6.80	12	9.20	
Rehab	11	2.90	6	2.40	5	3.80	
No organisation given	24	6.30	15	6.00	9	6.80	

[1]Overall percentile.

[2]Within group percentiles (i.e., early- and late-onset).

[3]*p*-value between onset-types across sociodemographic categories; *p* is significant at $p = 0.05$

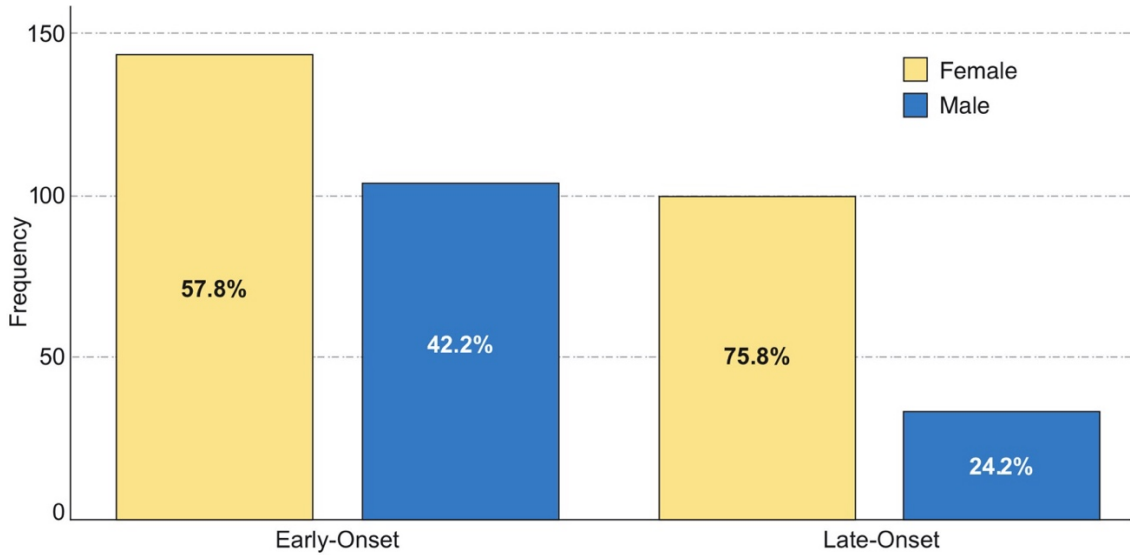
[4]Chi-square statistics were undertaken to ascertain if there was a relationship between onset-type and the categories 'Belief System' and 'Organisation where the Respondents found Recovery'. There was a significant relationship between 'Belief system' and the 'Organisation where the Respondents found Recovery' in the early-onset cohort ($p = <0.001$); the same relationship with regard to the late-onset cohort was not significant ($p = <0.666$).

Gender

The overall sample consisted of 244 (64.0%) female and 137 (36.0%) male respondents (N = 381). Regarding onset-type, the early-onset group consisted of 144 (57.8%) females and 105 (42.2%) males (total early-onset N = 249), while the late-onset group consisted of 100 (75.8%) females and 32 (24.2%) males (total late-onset N = 132). Figure 6.2 shows the percentiles for both onset-types. The data presented above and in table 6.2 and figure 6.2 suggests there is an association between gender and onset-type. Chi-square statistics were undertaken to explore if there was an association between the two categorical variables of gender and onset-type. The chi-square test confirmed there is a significant relationship between gender and onset type (x^2 = 12.038, df = 1, p = <0.001). Additionally, an *OR* analysis undertaken to assess the ratios between gender and onset-type showed that female respondents were almost one and a half times more likely than male respondents to be early-onset (1.4; 37.80% versus 27.55% of the total sample respectively). However, by comparison, the late-onset/gender ratio was greater and showed that female respondents were over three times more likely than male respondents to be late-onset (3.2; 26.24% versus 8.40% of the total sample respectively; *OR* = 0.43, 95% CI, [0.70, 0.27]).

Figure 6.2.

Gender Distribution by Onset-type (Within Group Percentile Values).



Sexual identity

The overall sample consisted of 343 (90.0%) individuals who identified as heterosexual, 20 (5.25%) who identified as LGBTQ, and 18 (4.75%) who preferred not to disclose their sexual identity (N = 381). Regarding onset-type, the early-onset group consisted of 223 (91.7%) individuals who identified as heterosexual, 13 (4.5%) who identified as LGBTQ, and 13 (3.8%) who preferred not to disclose their sexual identity (total early-onset N = 249). Within the late-onset group, 120 (90.0%) individuals identified as heterosexual, seven (5.3%) identified as LGBTQ, and five (4.7%) preferred not to disclose their sexual identity (total late-onset N = 132). Chi-square statistics were undertaken to explore the relationship between 'sexual identity' and onset-type. The Chi-square test found that the relationship between the two variables was not significant (x^2 = 0.626, df = 2, p = 0.731).

Relationship status

The overall sample consisted of 218 (57.2%) individuals who were married or cohabiting, 95 (24.90%) who were divorced or separated, 17 (4.5%) who were widowed, and 51 (13.4%) who were single (N = 381). Regarding onset-type, the early-onset group consisted of 130 (51.8%) individuals who were married or cohabiting, 66 (26.5%) who were divorced or separated, 13 (5.2%) who were widowed, and 40 (16.5%) who were single (total early-onset N = 249). Within the late-onset group, 88 (67.4%) individuals were married or cohabiting, 29 (22.0%) were divorced or separated, four (3.0%) were widowed and 11 (7.6%) were single (total late-onset N = 132). Chi-square statistics explored the relationship between 'relationship status' and onset-type. A chi-square test found the relationship between the two variables was significant (x^2 = 10.41, df = 3, p = 0.015); Cramer's V (0.16) indicated that the relationship was weak.

Number of times in residential treatment

The overall sample consisted of 65 (17.1%) individuals who had been in residential treatment once, 58 (15.2%) who had been in residential treatment more than once, and 258 (67.7%) who had never been in residential treatment ($N = 381$). Regarding onset-type, the early-onset group consisted of 39 (15.7% of group) individuals who had been in residential treatment once, 44 (17.7% of group) who had been in residential treatment more than once, and 166 (66.6% of group) who had never been in residential treatment (total early onset $N = 249$). Within the late-onset group, 26 (19.7% of group) individuals had been in residential treatment once, 14 (10.6% of group) had been in residential treatment more than once, and 92 (69.7 of group) had never been in residential treatment (total late-onset $N = 132$). Chi-square statistics were undertaken to explore the relationship between the 'number of times in residential treatment' and onset-type. The Chi-square test found that the overall relationship between onset-type, regarding being in treatment, was non-significant ($x^2 = 3.77$, df = 2, $p = 0.15$).

Belief system

From the overall sample, 71 (18.6%) individuals were religious, 130 (34.0%) were not religious but believed in a concept of God, 127 (33.4%) described their belief system as secular or spiritual[4], while 53 (14.0%) had no spiritual beliefs ($N = 381$). Regarding onset-type, within the early-onset group, 44 (17.7%) individuals were religious, 92 (36.9%) were not religious but believed in a concept of God, 78 (31.3%) described their belief system as secular or spiritual, and 35 (14.1%) had no spiritual beliefs (total early-onset $N = 249$). Within the late-onset group, 27 (20.5%) individuals were religious, 39 (28.8%) were not religious but believed in a concept of God, 48 (37.1%) described their belief system as secular or spiritual, and 18 (13.6%) had no spiritual beliefs (total late-onset $N = 132$).

Figure 6.3

Belief System by Onset-type (Within Group Percentile Values).

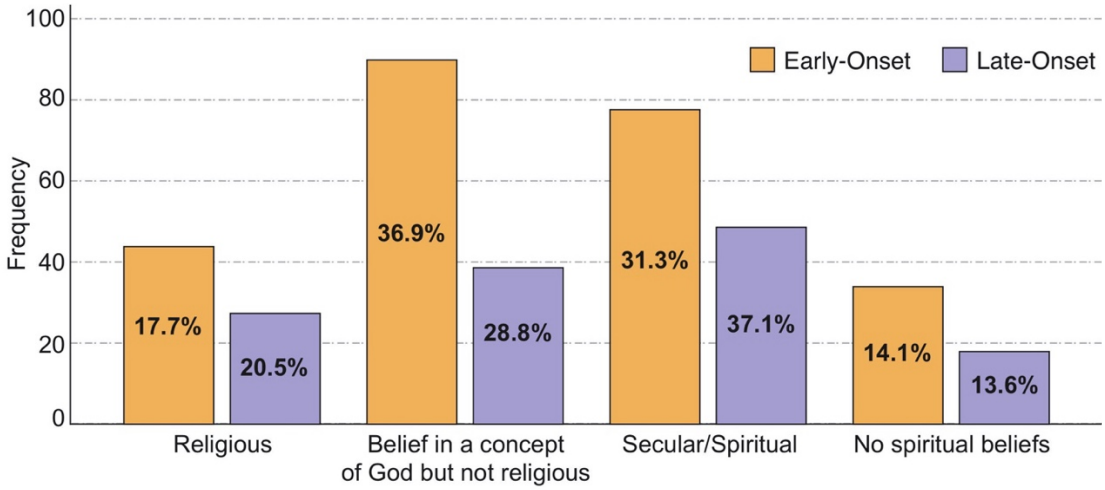


Table 6.3

Belief System by Onset-type, in Relation to Organisation where Recovery was Found

		Belief System/Spirituality				
	Organisation where recovery was found	Religious	Belief in a concept of God but not Religious	Secular/ Spiritual	No Spiritual Beliefs	Total
Early-Onset	AA	25	60	39	11	135
	SMART Recovery	1	2	6	1	10
	UK CDAS	0	5	2	6	13
	NHS	1	2	1	3	7
	Other (Various)	10	8	18	10	46
	Self	2	8	3	4	17
	No Organisation Named	2	6	7	0	15
	Rehab	*3*	*1*	*2*	*0*	*6*
	Total	*44*	*92*	*78*	*35*	*249*
Late-Onset	AA	11	11	15	1	38
	SMART Recovery	2	1	2	2	7
	UK CDAS	1	3	3	2	9
	NHS	1	2	2	1	6
	Other (Various)	6	12	21	7	46
	Self	3	5	3	1	12
	No Organisation Named	1	3	2	3	9
	Rehab	2	1	1	1	5
	Total	*27*	*38*	*49*	*18*	*132*
Sample Totals	AA	36	71	54	12	173
	SMART Recovery	3	3	8	3	17
	UK CDAS	1	8	5	8	22
	NHS	2	4	3	4	13
	Other (Various)	16	20	39	17	92
	Self	5	13	6	5	29
	No Organisation Named	3	9	9	3	24
	Rehab	5	2	3	1	11
	Total	*71*	*130*	*127*	*53*	*381*

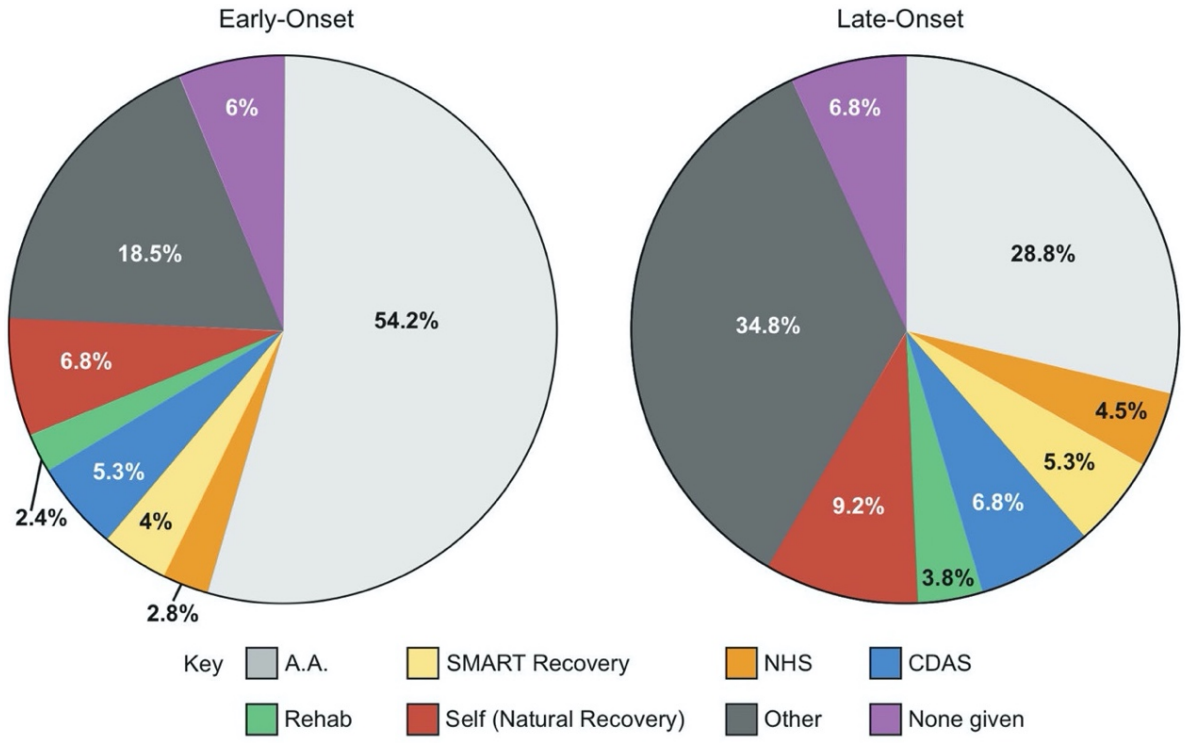
Organisation[5] where the respondents found recovery

Within the overall sample 173 (45.4%) respondents credited A.A. as the organisation where they found recovery, 13 (3.4%) credited the NHS, 17 (4.5%) credited SMART Recovery, 22 (5.8%) credited UK CDAS, 11 (2.9%) found recovery when they were in rehab, 29 (7.6%) credited themselves (recovered naturally), 92 (24.1%) credited various other organisations with the beginning of their recovery, and 24 (6.3%) did not respond to the question (N = 381). Regarding the ratios of these categories in the context of onset-type, refer to table 6.2. It is noteworthy that 54.2% of the early-onset respondents credited A.A. as the organisation where they found recovery, compared to 28.8% of the late-onset respondents, and 18.5% of the early-onset respondents found recovery in the 'other organisations' category, compared to 34.8% of the late-onset cohort in the same category. The percentile differences presented in table 6.2 and figure 6.4 suggests there is an association between onset-type and the 'organisation where recovery was found'. Chi-square statistics were undertaken to explore if there was an association between these categorical variables. The Chi-square test confirmed there was a significant relationship between onset-type and the 'organisation where recovery was found' ($x^2 = 24.56$, df = 7, $p = <0.001$). Cramer's V (0.25) indicated that the association was moderate, but that A.A. was more strongly associated with the early-onset group.

Further chi-square statistics were undertaken to explore if there were associations between the categorical variables of the 'organisation where the respondents found recovery' and 'belief system' in relation to onset-type. The Chi-square test confirmed that there was a significant relationship between 'belief system' and the 'organisation where the respondents found recovery' in the early-onset cohort ($x^2 = 47.26$, df = 21, $p = <0.001$). The same relationship in the in relation to the late-onset cohort was not significant ($x^2 = 17.73$, df = 21, $p = 0.666$).

Figure 6.4

Recovery Organisation by Onset-type (Within Group Percentile Values).



Continuous years in recovery

Continuous years in recovery (and abstinence from alcohol) in the sample as a whole, ranged from one-year to 52-years ($M = 9.44$, $SD = 11.81$, $N = 381$). Regarding onset-type, 'continuous years in recovery' in the early-onset group ranged from one-year to 52-years ($M = 12.71$, $SD = 13.23$, $N = 249$), while 'continuous years in recovery' within the late-onset group ranged from one-year to 20-years ($M = 3.27$, $SD = 3.84$, $N = 132$). An independent-sample *t*-test was conducted to compare the 'continuous years in recovery', between the early-onset group and the late-onset group. The *t*-test showed there was a significant difference (t (318) = 8.02, p = <0.001) between the early-onset group and the late-onset group regarding 'continuous years in recovery'. The mean score for the early-onset group ($M = 12.71$, $SD = 13.23$) was significantly higher than the mean score for the late-onset group ($M = 3.27$, $SD = 3.84$). The magnitude of the differences in the means (mean difference = 9.450, 95% *CI*: 7.67 to 11.26) was significant.

N.B. For output/results of the descriptive and inferential statistics above, refer to *Appendix 6.2*.

6.3.3 **Purpose in Life test** (Crumbaugh & Maholick, 1964)

Purpose in Life test scores in relation to Onset-type

An independent-sample *t*-test was conducted to compare PIL test scores between the early- and late-onset groups. The results indicated there was no significant difference (t (379) = .860, p = 0.39) in PIL test scores between the groups. The mean score for the early-onset group (M = 99.08, SD = 20.01) was slightly higher than the mean score for the late-onset group (M = 97.29, SD = 17.63). The magnitude of the differences in the means (mean difference = 1.78, 95% *CI*: -2.29 to 5.87) was not significant. The results suggest that the degree of purpose in life in problem drinkers in recovery is not associated with onset-type.

Purpose in Life test scores in relation to Gender

A further independent-sample *t*-test was conducted to compare Purpose in Life test scores between female respondents and male respondents. The results indicated there was no significant difference (t (379) = -.002, p = 0.99) in the Purpose in Life test scores between female and male respondents. The mean score for females (M = 98.46, SD = 19.00) was equal to the mean score for males (M = 98.46, SD = 19.91). The magnitude of the differences in the means (mean difference = -.004, 95% *CI*: -4.06 to 4.05) was not significant. The results suggest that the degree of purpose in life in problem drinkers in recovery is not associated with gender.

Purpose in Life test scores in relation to Organisations where Recovery was found

A one-way ANOVA was performed to compare differences in Purpose in Life test scores in the eight groups within the 'organisations where recovery was found' category (i.e., A.A.; SMART Recovery; UK CDAS; NHS; Other; Self; Rehab; No organisation given). The ANOVA results showed that, overall, the Purpose in Life test scores of the groups were significantly different (F(7, 373) = 3.21, p = <0.003). Because the Levene's test of homogeneity of variances was not significant (p = 0.87), equal variances were assumed. To check for individual differences between groups, post hoc comparisons were assessed using

Bonferroni. The test indicated that the mean Purpose in Life test scores for participants in the A.A. group (M = 102.20, SD = 18.88) were significantly different from the mean Purpose in Life test scores for participants in the UK CDAS group (M = 85.68, SD = 18.38). There were no significant differences in PIL test scores between any of the other group comparisons. One-way ANOVAs were also performed to ascertain if there were differences in Purpose in Life test scores between groups in four of the other demographic categories (i.e., 'sexual identity'; 'relationship status'; 'belief system'; 'number of times in residential treatment'). No significant differences were found between PIL test scores and any of these demographic categories

Purpose in Life test scores in relation to Continuous Years in Recovery

A Pearson product correlation was undertaken to determine the relationship between Purpose in Life test scores and 'continuous years in recovery'. An inspection of the scatterplot and histograms showed that the assumptions of linearity and homoscedasticity had not been met. Further, Shapiro-Wilk tests showed that the data across Purpose in Life test scores, $W(381)$ = .98, p = <0.001, and 'continuous years in recovery', $W(381)$ = .74, p = < .001, were not distributed normally. Therefore, a Spearman rank-correlation was undertaken to examine the relationship between Purpose in Life test scores, and 'continuous years in recovery'. The results of the analysis showed that there was a weak, positive, and significant relationship between Purpose in Life test scores and 'continuous years in recovery', r_s = .32, n = 381, p = <0.001. These findings suggest that as years in recovery increase, one's purpose in life increases and supports one of the thesis' hypotheses', '*that, regardless of onset-type, there is an association between the level of MPL in individuals in recovery and their time in recovery*.

N.B. For SPSS output/results of all of the inferential statistical tests undertaken, relating to the Purpose in Life test above, refer to *Appendix 6.5*.

6.3.4 Meaning in Life Questionnaire (MLQ; Steger et al., 2006)

6.3.4.1 MLQ (presence)

MLQ (presence) scores in relation to Onset-type

An independent-sample *t*-test was conducted to compare MLQ (presence) scores between the early- and late-onset groups. The results indicated that there was no significant difference (t (379) = 0.38, p = 0.70) in MLQ (presence) scores between the groups. The mean score for the early-onset group (M = 24.57, SD = 7.26) was slightly higher than the mean score for the late-onset group (M = 24.28, SD = 6.62). The magnitude of the differences in the means (mean difference = 0.28, 95% *CI*: -1.78 to 1.74) was not significant. The results suggest that the degree of meaning in life in problem drinkers in recovery is not associated with onset-type.

MLQ (presence) scores in relation to Gender

An independent-sample *t*-test was conducted to compare MLQ (presence) scores between female respondents and male respondents. The results indicated that there was no significant difference (t (379) = 0.97, p = 0.33) in MLQ (presence) scores between female respondents and male respondents. The mean score for female respondents (M = 24.73, SD = 6.87) was slightly higher than the mean score for the male respondents (M = 24.00, SD = 7.32). The magnitude of the differences in the means (mean difference = 0.73, 95% *CI*: -.74 to 2.21) was not significant. The results suggest that the degree of meaning in life in problem drinkers in recovery is not associated with gender.

MLQ (presence) scores in relation to Organisations credited with beginning of Recovery

A one-way ANOVA was performed to compare differences in MLQ (presence) scores between the eight groups that formed the 'organisation where recovery was found' category. The ANOVA results showed that overall, there was a statistically significant difference in MLQ scores across the groups (F(7, 373) = 2.57, p = <0.013). Because the Levene's test of homogeneity of variances was not significant (p = 0.86), equal variances were assumed. To

check for individual differences between groups, post hoc comparisons were carried out using Bonferroni. Although there was an overall significant difference across the groups, the post hoc test also indicated that there were no individual significant differences in MLQ (presence) scores between any of the group comparisons. One-way ANOVAs were performed to ascertain if there were differences in MLQ (presence) scores between groups in four of the other demographic categories (i.e., 'sexual identity'; 'relationship status'; 'belief system'; 'number of times in residential treatment'). No significant differences were found between MLQ (presence) scores and any of these demographic categories.

MLQ (presence) scores in relation to Continuous Years in Recovery

A Pearson product correlation was performed to determine the relationship between MLQ (presence) scores and 'continuous years in recovery'. An inspection of the histogram and scatter plot indicated that the assumptions of linearity and homoscedasticity had been violated. Further analysis, in the form of a Shapiro-Wilk test, indicated that the data across the two variables were not distributed normally: MLQ (presence) scores, $W(381) = .95$, $p = <0.001$, 'continuous years in recovery', $W(381) = .74$, $p = <0.001$. Because the data were not normally distributed across the two measures, Spearman's rank-correlations were undertaken to examine the relationships between MLQ (presence) scores, and 'years in continuous recovery'. The results of the analysis showed that the relationship between MLQ (presence) scores and 'continuous years in recovery' was moderately positive and statistically significant, $r_s = .30$, $n = 381$, $p = < .001$. Similarly, to the relationship between Purpose in Life test scores and 'continuous years in recovery', these findings suggest that as years in recovery increase, the presence of meaning in life increases. Moreover, the findings further support the thesis' hypothesis', *that, regardless of onset-type, there is an association between the degree of MPL in individuals in recovery and their time in recovery*.

N.B. For SPSS output/results of all of the inferential statistical tests undertaken, relating to MLQ (presence) above, refer to *Appendix 6.5*.

6.3.4.2 MLQ (search)

MLQ (search) scores in relation to Onset-type

An independent-sample *t*-test was conducted to compare MLQ (search) scores between the early-onset group and the late-onset group. The results indicated that there was a significant difference (t (308) = -2.45, p = 0.01) in MLQ (search) scores between the early-onset group and the late-onset group. The mean score for the early-onset group (M = 23.15, SD = 7.05) was slightly lower than the mean score for the late-onset group (M = 24.83, SD = 5.94). The magnitude of the differences in the means (mean difference = -1.68, 95% *CI*: -3.02 to -.33) was significant. The results suggest that there is a relationship between the search for meaning in life and onset-type.

MLQ (search) scores in relation to Gender

An independent-sample *t*-test was conducted to compare MLQ (search) scores between female respondents and male respondents. The results indicated that there was no significant difference (t (378) = 0.88, p = 0.37) in MLQ (search) scores between the female respondents and male respondents. The mean score for female respondents (M = 23.96, SD = 6.65) was slightly higher than the mean score for the male respondents (M = 23.32, SD = 6.87). The magnitude of the differences in the means (mean difference = 0.63, 95% *CI*: -.77 to 2.04) was not significant. The results suggest that the search for meaning in life in problem drinkers in recovery is not associated with gender.

MLQ (search) scores in relation to five sociodemographic categories.

One-way ANOVAs were performed to compare differences in MLQ (search) scores between groups in five of the study's sociodemographic categories: 'organisations where recovery was found'; 'sexual identity'; 'relationship status'; 'belief system' and 'number of times in

residential treatment'. No significant differences were found between MLQ (search) scores and any of these demographic categories

MLQ (search) scores in relation to Continuous Years in Recovery

A Pearson product correlation was performed to determine the relationship between MLQ (search) scores and 'continuous years in recovery'. An inspection of the histogram and scatter plot indicated that the assumptions of linearity and homoscedasticity had been violated. Further analysis, in the form of a Shapiro-Wilk test, indicated that the data across the two variables were not distributed normally: MLQ (search) scores, $W(381) = .94$, $p = <0.001$, 'continuous years in recovery', $W(381) = .74$, $p = <0.001$. Because the data were not normally distributed across the two measures, Spearman's rank-correlations were undertaken to examine the relationships between MLQ (search) scores, and 'continuous years in recovery'. The results of the analysis showed that the relationship between MLQ (search) scores and 'continuous years in recovery' was weak, negative and statistically significant, $r_s = -.14$, $n = 381$, $p = 0.005$. These results indicated that MLQ (search) scores tended to be higher in respondents with fewer years in recovery, and that as 'continuous years in recovery' increase, MLQ (search) scores decrease, suggesting that people with fewer 'continuous years in recovery', are more likely to be searching for meaning in life, than people with more 'continuous years in recovery'.

N.B. For SPSS output/results of all of the inferential statistical tests undertaken above, relating to MLQ (search), refer to *Appendix 6.5*.

6.3.5 Purpose in Life test, MLQ (presence), and MLQ (search) scores correlated

A Pearson product correlation was undertaken to examine the relationships between Purpose in Life test scores, MLQ (presence) scores, and MLQ (search) scores. An inspection of histograms and scatterplots indicated that the assumptions of linearity and homoscedasticity, between Purpose in Life test scores and MLQ (presence) scores had not been violated, however, the same assumptions between Purpose in Life test scores and MLQ (search) scores,

and between MLQ (presence) scores and MLQ (search) scores had been violated. Additionally, a Shapiro-Wilk test indicated that the data across the three measures were not distributed normally: Purpose in Life test scores, $W(381) = .98$, $p = < .001$, MLQ (presence) scores, $W(381) = .95$, $p = <0.001$, and MLQ (search) scores, $W(381) = .94$, $p = <0.001$. Because the data were not normally distributed across the three measures, Spearman's rank-correlations were undertaken to examine the relationships between Purpose in Life test scores, MLQ (presence) scores, and MLQ (search) scores. The results of the analysis showed that: 1. There was a strong, positive, and significant relationship between Purpose in Life test scores and MLQ (presence) scores, $r_s = .78$, $n = 381$, $p = <0.001$, suggesting that the constructs of purpose in life and meaning in life are in tandem and that as one construct increases so too does the other construct. 2. There was a weak, negative, and significant relationship between Purpose in Life test scores and MLQ (search) scores, $r_s = -.14$, $n = 381$, $p = 0.006$, suggesting that individuals searching for a meaning in life have a degree of purpose in life too. 3. There was a weak, negative, and significant relationship between MLQ (presence) scores and MLQ (search) scores, $r_s = -.192$, $n = 381$, $p = <0.001$. The strength (i.e., weak) and direction (i.e., negative) of these two constructs, however, suggests that the relationship between the search for meaning in life and the presence of meaning in life is not a strong one; this is not surprising, as they are contradictory constructs.

Table 6.4a

Spearman Rank-Correlations for Purpose in Life test scores, MLQ (presence) scores and MLQ (search) scores

	Purpose in Life Score	MLQ (presence) Score	MLQ (search) Score
Purpose in Life score	1		
MLQ (presence) score	.78**	1	
MLQ (search) score	-.14**	-.19**	1

**. Correlation is significant at the 0.01 level (2-tailed)

Table 6.4b

Purpose in Life test and MLQ Scores, by Onset-type.

	Minimum	Maximum	Mean	Std. Deviation
Early-onset Purpose in Life	38	139	99.08	20.14
Late-onset Purpose in Life	45	132	97.29	17.30
Early-onset MLQ (presence)	5	35	23.15	7.05
Late-onset MLQ (presence)	8	35	24.83	5.94
Early-onset MLQ (search)	5	35	24.57	7.26
Late-onset MLQ (search)	9	34	24.28	6.62

N.B. For output/results of the statistical tests relating to the above, refer to *Appendix 6.5*.

6.4. DISCUSSION

Defining late-onset problem drinking

Before considering the research questions mentioned earlier in the text and fully investigating the questionnaire/survey data, it was essential to define approximate onset ages for early- and late-onset problem drinking. The earlier literature review suggested that late-onset problem drinking is likely to emerge in people at approximately 50-years-old; an estimation calculated on the mean onset-age of the 26 papers in the review, that ranged from >40 years-old (Wadd et al., 2011) to ≥60 years-old (Atkinson et al., 1990). The current study proposed ≥45-years-old as a lower-end onset-age for late-onset problem drinking, an onset-age also defined by Kist et al. (2014), Van den Berg et al. (2014), and Wetterling et al. (2003). This decision was based on the data, that showed a sharp rise in drinking between 45-years-old and 50-years-old.

Furthermore, having set the lower-end onset-age for late-onset problem drinking at ≥45, the study suggests that late-onset problematic drinking, as defined by this study, is most likely to emerge within a ten-year time frame, between 45 and 55-years-old; a time span when 84% of the late-onset cohort reported their drinking as becoming problematic. Interestingly, Moorhead (1958) the first researcher to identify a unique group of older problematic drinkers, identified the same age range in his sample of "61 patients in whom alcohol became a problem at 45 years of age, or older" (p. 108), with a mean age when drinking became problematic of, "between 49 and 50" (p. 101); the term 'late-onset' was not then in usage. It is also worth

noting that ten participants in his study had natural recoveries, which Moorhead (1958) described as "instances of spontaneous abstinence without treatment" (p. 100).

Onset-type and sociodemographic characteristics

There was a significant difference in gender ratios between the two groups, with a 3/1 ratio (75.8% females, 24.2% of males) in the late-onset cohort, compared to the early-onset group, comprised of 57.8% females and 42.2% males. These ratios support similar gender findings on the topic (Brennen, & Moos, 1991; Van Montfoort-De Rave et al., 2017). The differences in gender ratios are a particularly interesting phenomenon, because women over 50-years of age tend to be less likely than men to admit to having a drinking problem (Drummond et al., 2016; Gell et al., 2015), most likely because of denial (Pretorius et al., 2009), driven by the stigma associated with alcohol misuse, which is more prevalent among women than men (Blow, 2000; Dragišić Labaš, 2016; Hecksher, & Hesse, 2009). Regardless of the reason, compared to men, women are less likely to acknowledge having a problem with alcohol and delay seeking help (Blow & Barry, 2002; Green, 2006; Pretorius et al., 2009). That many women do seek help, may be explained, in part, by the higher levels of abstinence self-efficacy found in female problem drinkers in recovery, compared to male problem drinkers (Bischof et al., 2005; Kelly, & Hoeppner, 2013).

There were no marked differences between the two cohorts in the context of 'sexual identity'. Regarding 'relationship status', there was a significant (but weak) relationship. For instance, compared to early-onset respondents, a greater percentile of late-onset respondents, were either married or cohabiting (51.8% and 67.4% respectively), consequentially, the percentile of early-onset respondents who were single (16.5%) was more than twice as much as the single percentile for late-onset respondents (7.6%). A significant relationship was found in the early-onset cohort between the respondents' 'belief system' and the 'organisation where recovery was found'; the same relationship was found to be insignificant in the late-onset

group. Overall, in common with the general population, which has seen a continuing decline (globally) in religious practices (Brauer, 2018; Hirschle, 2010; Inglehart, 2020; Reader, 2012), the percentile of respondents, as a whole, who reported having a religious belief system was small (18.6%). In contrast, one-third (34%) of respondents reported having a deistic belief system, that is, the belief in the existence of a non-interventionist God or supernatural entity, that is not formalised in a religious belief system. This might be because almost half (45.60%) of the respondents were affiliated to A.A. (two-thirds of whom were early-onset), whose 12-step programme encourages its members to make "a decision to turn our will and our lives over to the care of God *as we understand him*" (A.A., 2001, p. 59)[6]. The significant relationship found in the early-onset cohort between 'belief system' and the 'organisation where recovery was found', supports this explanation. A further third of the sample reported being either secular or spiritual. Approximately two-thirds of all respondents had never been in residential treatment, and although more early-onset respondents (17.7%) had been in residential treatment once, compared to the late-onset cohort (10.6%), more of the late-onset had been in residential treatment more than once (19.7%), compared to the early-onset group (15.7%).

With the exception of gender, the most significant differences between the two cohorts, were in the final two sociodemographic categories, 'organisation where recovery was found' and 'continuous years in recovery'. As noted above, almost half of the respondents credited A.A. with the beginning of their recovery. However, whereas more than half (54.6%) of the early-onset cohort credited A.A., a much smaller percentile of the late-onset group, just over a quarter (28.8%) credited A.A. with the beginning of their recovery, suggesting that late-onset problem drinkers are more likely to choose alternative mutual-aid recovery pathways. Chi-square tests performed earlier in the text, which found moderately significant differences between onset-type and 'organisation where recovery was found', supports this suggestion (for further context also refer to endnotes on p. 230).

Until (relatively) recently, A.A. dominated the mutual-aid organisation model of recovery pathways. Nowadays, however, there are a plethora of mutual aid organisations, giving problem drinkers seeking recovery far greater choice (also refer to *Appendix 6.4*), something that has been well documented by leading researchers in the field of alcohol and other drug problems (Humphreys, & Klaw, 2001; White, 2004; White et al., 2012), as have natural recovery pathways too (Best et al., 2018; Cloud, & Granfield, 2001). However, there was a significant difference in 'continuous years in recovery' between early- and late-onset problem drinkers (M = 12.71 years and M = 3.71 years respectively). Moreover, t-test results found that individuals who found recovery in A.A. had significantly more 'continuous years in recovery' than people who found recovery at other organisations. The ongoing meeting attendance behaviour[7] of many A.A. members means that it is much easier to record and report A.A. members' continuous years in recovery (A.A., 2022).

Purpose in Life test

There were no significant differences in Purpose in Life test scores between early-onset problem drinkers in recovery (M = 99.08, SD = 20.01) and late-onset problem drinkers in recovery (M = 97.29, SD = 17.63). There were also no significant gender differences in Purpose in Life test scores (females, M = 98.46, SD = 19.00; males M = 98.46, SD = 19.91). There was a significant difference in Purpose in Life test scores across the 'organisation where recovery was found' category. However, on closer inspection, the difference was between A.A. (whole sample total, N = 173) and UK CDAS (whole sample total, n = 22) only, and there were no significant differences between any of the other groups in the category, so the single significant difference between A.A. and UK CDAS is not particularly meaningful. Interestingly, as hypothesised earlier, a significant relationship was found between Purpose in Life test scores and length of time in recovery, that is, Purpose in Life increases with time in recovery. The findings support similar findings on the association between increased Purpose in Life and time

in recovery (Krentzman et al., 2015; Krentzman et al., 2017; Oakes, 2008; Robinson et al., 2011), suggesting that purpose in life is a temporal, developmental process, and increases in tandem with increased time in continuous recovery (McInerney et al, 2021), which many people achieve within mutual-aid groups.

An integral component of the mutual-aid model of recovery is peer-based recovery support, the notion of a recovering problem drinker helping other problem drinkers; supporting others gives the helper a greater PIL (White, 2009; White et al., 2012). In logotherapy, this kind of selfless behaviour is referred to as *dereflection*, a Franklian concept, which in essence, is a psychoanalytical technique aimed at transforming negative thoughts into positive ones. Central to logotherapy, dereflection is the final step in helping individuals to find purpose and meaning in their lives. According to Henrion (1987), when people "dereflect from their shortcomings to their assets and successes, they find new goals and make their lives worthwhile" (p. 116). Robert Crumbaugh (1981), co-developer of the Purpose in Life test applied logotherapeutic techniques to several of his patients with alcohol problems. Many of those patients had successful outcomes and recovered. According to Crumbaugh (1981), they became "alcoholism therapists: their new meaning and purpose in life has been to help other alcoholics" (p. 29). Crumbaugh (1981) found that the key predictor of his patients having successful outcomes was motivation, which mediates self-efficacy (Bandura 1982; Bandura, & Schunk 1981). Similarly, logotherapy is based on motivation, whereby the therapist motivates the individual to access self-efficacy and generate their own MPL. Indeed, Frankl's existential psychology has been proposed as a theory of motivation (Esping, 2018).

MLQ

As previously discussed, the MLQ consists of two subscales, designed to measure two psychological constructs, the *presence* of meaning life and the *search* for meaning life. In the context of onset-type, there were no significant differences between the early- and late-onset

cohorts regarding a *presence* of meaning in life; there were also no significant gender differences reported in this construct. However, there was a significant relationship between the *presence* of meaning life and 'continuous years in recovery', that is, in common with purpose in life, the *presence* of meaning life increases with time recovery. In the context of the *search* for meaning life, significant differences were found between the groups in the *search* for meaning life. Further statistical investigations found a negative, significant correlation between years in recovery and the *search* for meaning life, suggesting that the *search* for meaning life is greater in people with fewer 'continuous years in recovery', and subsequentially decreases in individuals as 'continuous years in recovery' increase. It is reasonable to assume that life has greater meaning for problem drinkers in recovery, compared to when they were actively drinking. Therefore, the study's finding that suggests that people who have a greater length of time in recovery tend to have a greater *presence* of meaning life, than those with less time in recovery is not surprising. Moreover, these findings agree with a considerable body of evidence, that also suggest that MPL increases with time in recovery (e.g., Chen, 2006b; Junior, 2006; Kleinig, 2008; Laudet, & White, 2010; McInerney, & Cross, 2021; McInerney et al., 2022; White, 2007), and again, support the hypothesis, *that, regardless of onset-type, there is an association between the degree of MPL in individuals in recovery and their time in recovery*.

6.4.1 Summary of findings

- The study defined early-onset as problem drinking beginning before 45-years-old.
- The study defined late-onset as problem drinking beginning at or after 45-years-old.
- Approximately two-thirds of respondents were defined as early-onset and approximately one-third of respondents were defined as late-onset.
- There was a significant relationship between gender and onset-type. Compared to the early-onset group (57.8% female vs 42.2% male), there were significantly more females (75.8%) than males (24.2%) in the late-onset cohort.
- There was a significant relationship between onset-type and the organisation where recovery was found. The early-onset cohort were more likely to seek help from A.A. than the late-onset group, who were more likely to seek help from alternative mutual-aid recovery pathways.
- Early-onset drinkers had significantly more continuous years in recovery and abstinence from alcohol than late-onset drinkers.
- There were no significant differences in Purpose in Life test scores between early- and late-onset problem drinkers in recovery.
- There were no significant gender differences in Purpose in Life test scores.
- There was a strong positive, significant relationship between Purpose in Life test test scores and continuous years in recovery, suggesting that as time in recovery increases, purpose in life increases.
- There was a significant difference between Purpose in Life tests scores and the organisation where recovery was found category.
- There was a positive, significant relationship between MLQ (presence) scores and continuous years in recovery, suggesting that as time in recovery increases, the presence of meaning in life increases.
- There was a significant difference in MLQ (search) scores between early- and late-onset respondents, suggesting that there is a relationship between the search for meaning in life and onset-type.
- There was a negative, significant relationship between MLQ (search) scores and continuous years in recovery, which suggested that the search for meaning in life is greater in people who have fewer years in recovery.
- There was a strong, positive, significant relationship between PIL test scores and MLQ (presence) scores, suggesting that PIL and meaning in life increase in tandem.

6.4.2 Concluding remarks and implications

The study's results should be considered in the context of the three relevant research questions and single hypothesis listed earlier in the text, and again here:

- *Investigate the psychosocial characteristics of late-onset AUD/problem drinkers in recovery and compare them with the psychosocial characteristics of early-onset AUD/problem drinkers in recovery*.
- *Explore and compare the role of MPL, between early- and late-onset problem drinkers in recovery*.
- *Investigate and compare the recovery pathways of late-onset AUD/problem drinkers and early-onset AUD/problem drinkers*.
- *It was hypothesised that, regardless of onset-type, there is an association between the degree of MPL in individuals in recovery and their length of time in recovery*.

Conceptually, the current study and thesis, is viewed from the dichotomous perspective of early- and late-onset problem drinking. Therefore, before any of the above could be considered, it was necessary to determine a cut-off age for late-onset problem drinking. However, it was noted that the age when early-onset ends and late-onset begins can never be exact. This temporal dilemma is worth considering from different conceptual perspectives. For, example, when categorising onset-types by age, it was (reasonably) assumed that the 41.0% of the overall sample who began drinking problematically before the age of 30, were definitely early-onset. However, categorising the remaining 23.9% of respondents, who made up the 15 years between 30-years-old and the start of late-onset (approximately set at 45-years-old), as early-onset is not so straightforward, and encourages alternative explanations, two of which are presented here for consideration. Firstly, the 23.9% group could be viewed as another category; previous researchers, for example, have viewed problem drinking as a trichotomous variable, with some of these framing the three categories as early-, midlife- and late-onset (e.g., Atkinson et al.,

1990; Van Montfort-De Rave et al., 2017). In the context of the current study, the second alternative explanation is more radical. That is, rather than categorising problematic drinkers in terms of either dichotomous or trichotomous variables, defined by age, problem drinking can simply be viewed as a continuous variable. It is important, however, that the outcome of any decisions should be informed by one, simple consideration, and that is, which of these concepts is most beneficial to the well-being of problematic drinkers? This is something that will be explored further in the final chapter.

In terms of differences in psychosocial characteristics between the two groups, the main finding that there are significantly more late-onset women than late-onset men, compared to the gender ratio among early-onset problem drinkers, confirms and reinforces what is already known about gender differences between the two groups. Regarding recovery pathways in the context of mutual-aid groups and peer-based recovery support, it was noteworthy and interesting, that compared to the survey's early-onset respondents, the late-onset respondents were considerably less likely to approach A.A., instead choosing alternative mutual-aid pathways. This revealing statistic may be driven by two factors. Firstly, when many of the early-onset respondents who found recovery at A.A. (many of whom now have decades of continuous years in recovery), there were few alternative mutual-aid pathways to consider; that is no longer the case. Secondly, and closely related to the first factor, is that the diversity of people seeking recovery from problem drinking is a microcosm of society in general, and is a reflection of societal changes, including the ever-evolving secularisation of society. However, his does not suggest that A.A. is diminishing or in decline. Rather, the study's findings suggest that given the multitude of alternative mutual-aid pathways, many people now seeking recovery, including late-onset problem drinkers, might be less willing to accept A.A's tenets, which arguably, are informed by the temporal and cultural context in which A.A. was created and developed.

The study's findings, that as well as being integral components to recovery, purpose in life and meaning life assume greater importance as time in recovery increases. Finally, purpose in life and meaning life are typically presented as a single construct, i.e., MPL. The chapter's title, however, suggests that purpose in life precedes meaning life, and that PIL and meaning life might be two, closely related, but different constructs. The difference between the two constructs is not only a question of semantics it is a philosophical one too. It could be argued, however, that purpose in life and meaning life are inseparable constructs, and may be mutually generative and supportive. The relationship, along with a number of other important considerations (referred to earlier in the text) are discussed further in the next and final chapter.

Chapter endnotes

1. Allostasis refers to the underlying processes that are essential to maintaining homeostatic equilibrium (McEwen, 2013). Allostatic load, or overload, is the level of "chronic, uncontrollable" and "toxic" stress that individuals can sometimes experience (p. 12).
2. The quote originally reads "As far as we can discern the sole purpose of human existence is to kindle a light in the darkness of mere being." (Jung, 1983, p. 358). The words 'of meaning' were inserted, so that the quote reads, "As far as we can discern the sole purpose of human existence is to kindle a light of meaning in the darkness of mere being."
3. The rationale for viewing the onset of problematic drinking from a dichotomous perspective (i.e., early- and late-onset), is set-out in chapter three, under the section, *3.9.4 Defining early- and late-onset participants* (p. 101), *Methodology and Theoretical Framework*.
4. Spiritual here, refers to the individual's belief that their existence has a spiritual aspect that is neither theistic nor deistic, i.e., the individual does not subscribe to the concept of a divine entity/deity/God but does believe in the notion of individual transcendence.
5. Six of the eight groups accounted for 69.6% (N = 265) of the respondents: A.A., NHS, SMART Recovery, UK CDAS, rehab and self (natural recovery). 6.3% (N = 24) respondents did not give an answer. The remaining 24.1% (N = 92) who constituted the 'Other' category, credited a further 28 organisations with their recoveries; 13 of these organisations, each accounted for one respondent only. The survey's respondents were located across 18 countries, with those from the UK (168; 44%) and the USA (162; 42.5%) constituting the largest geographical percentiles. *Appendix 6.4* lists the recovery organisations that the respondents' credited with finding their recoveries, along with the respondents' geographical locations.
6. In its early days, A.A. was closely affiliated to the Oxford Group, an evangelical Christian movement founded by Christian fundamentalist, Frank Buchman. The last four words in A.A.'s third step states, "Made a decision to turn our will and our lives over to the care of God *as we understand him*", were italicised in an attempt to

make A.A. more inclusive. However, that the Christian 'Lord's Prayer' is said at the end of all meetings in the USA, where A.A. originated, reinforces the argument that the 'God' that A.A. references, is a Christian God. For a comprehensive, fascinating and myth-breaking history of A.A.'s beginnings and the creation, construction and writing of A.A.'s primary text, *Alcoholics Anonymous*, refer to Schaberg (2019).

7. A major difference between A.A. and other mutual-aid groups is that for many of its members, A.A. becomes a way of life. Other mutual-aid groups (e.g., SMART Recovery) have more of an interventionist approach. That is, people are supported in their early recovery and then tend to stop going to meetings and move away from the group/organisation as their sobriety becomes firmly established. In contrast, A.A. members continue to attend meetings indefinitely, many for the rest of their lives. Although the sociodemographic data collected in the study did not ascertain if people still attended meetings of the recovery organisation where they found recovery, it is a reasonable assumption that many of the respondents who credited A.A. with the beginning of recovery, still attend A.A. meetings; this is because of the culture, described above.

CHAPTER SEVEN

DISCUSSION — FINDINGS, IMPLICATIONS & REFLECTIONS

"Meaninglessness inhibits fullness of life and is therefore equivalent to illness. Meaning makes a great many things endurable — perhaps everything."
(Jung, 1983, p. 373)

"I agree entirely with Frankl that man's primary concern (I would rather say "highest concern") *is his will to meaning."* (Maslow, 1966 p. 108)

7.1 INTRODUCTION

In common with Frankl, Jung and Maslow clearly felt that meaning was essential if one were to experience a complete and whole life. Indeed, similarly to Frankl's existential vacuum concept, Jung too, believed that a lack of meaning, born out of not having a purpose in life, restricted human fulfilment and was tantamount to being psychologically unwell. This chapter thoroughly examines and discusses the thesis' contents. Firstly, an overview of the thesis' findings is presented and summarised, followed by a consideration of the practical implications of the thesis' studies and what they have added to the existing evidence base. Theoretical implications are then discussed, specifically in the context of MPL, followed by a discussion on the implications that the thesis' findings could have in the context of recovery. Next, the chapter considers the knowledge and evidence the thesis has contributed to the area of late-onset problem drinking. Implications for policy and practice, the limitations of the thesis and considerations for future research are then discussed. The conclusion to the discussion is preceded by the author's reflective, first-person account of the thesis and the PhD journey. The reflective section is written from the insider perspective of someone who has lived experience of alcohol dependence and problematic drinking and subsequent recovery.

Historically, the language used to describe people with AUD/problem drinking has been stigmatising (Wakeman, 2019), and effectively, an agent for social othering (Morris et al., 2022). Such stigmatising language can have a negative impact on many late-onset problem drinkers and tends to affect late-onset women drinkers more than their male counterparts (e.g., Van Montfoort-De Rave et al., 2017; Wadd et al., 2011). Ultimately, the language of othering, has the potential to act as a barrier, that prevents people with alcohol and substance use disorders seeking help (Emiliussen et al., 2017b; Hammarlund et al., 2018; Kelly et al., 2010). It is now widely accepted that a stigma-free language is necessary in the context of people experiencing problems with alcohol and other drugs (e.g., Kelly et al., 2016; Matthews, 2019; Walmsley, 2023). The methodology chapter, therefore, pointed out that the language contained within the thesis would attempt to avoid negative, stigmatising language, and adhere to the call for a stigma-free, person-centred language[1].

7.2 SUMMARY OF THE THESIS' FINDINGS

This section summarises the findings of the systematic literature review and the thesis' three studies, all of which shared two focal points of investigation, the psychosocial characteristics of late-onset problem drinkers and the role of MPL. Moreover, the thesis' four components were investigated through the same theoretical lens, Frankl's theory of meaning: logotherapy. The findings from the literature review are a synthesis of existing knowledge, whereas the data generated by the three studies, adds to and reinforces existing knowledge. Additionally, there are several themes that converge across the data, forming common strands that keep the three studies and the literature review connected (e.g., gender differences, comorbid mental health). A summary of the literature review is presented first, followed by a synthesis of the findings from the two qualitative chapters, before finishing with a summary of the findings from the quantitative chapter.

7.2.1 A summary of the findings from the literature review

The starting point of a thesis is its literature review, the findings of which ultimately inform the contents of the main body of the thesis and its subsequent empirical findings. In common with many reviews, the literature review of the current thesis highlighted and synthesised two aspects of the object of investigation; firstly, what is known and, importantly, where further investigations were needed. Before embarking on the literature review, however, one has to consider and decide on the object of investigation. The origins of the thesis were born out of wanting to know why some people begin to drink problematically later in life. Additionally, the author had posited the notion that late-onset problem drinkers may be experiencing what Frankl (1963) conceptualised as an *existential vacuum*, i.e., a lack of MPL, and that excessive alcohol consumption is a way of coping with the resulting psychological emptiness. In turn, this led to adopting Frankl's theory of meaning, logotherapy, as the thesis' theoretical framework. From this rudimentary concept, two main questions emerged that could be addressed by the literature review.

Firstly, why do some people begin to drink problematically later in life? And secondly, does a lack of MPL (*existential vacuum*) contribute to this state of being? These two, fundamental questions were further refined to: 1) *What psychosocial characteristics have been reported in relation to people with late-onset AUD/problematic drinking?* 2) *To what degree has a lack of MPL been reported in relation to people with late-onset AUD/problematic drinking?* During preliminary investigations and selection of the final 26 papers included in the review, three common areas of investigation were identified: age of onset, gender differences and the psychosocial and the mental health characteristics of late-onset problem drinkers. Along with MPL, these three areas were used as an investigative framework to comprehensively investigate and explore the literature review's two research questions.

Standardising a cut-off age for late-onset problematic drinking was the starting point of the review's investigations. However, it is important to emphasise that the progression from being a social drinker, who has control over their alcohol consumption, to becoming a problematic drinker who has lost the power of control, is a gradual process for most people, it is not a sudden event. Thus, any findings or suggestions regarding standardising the age for late-onset problem drinking can only ever be approximate. Moreover, the onset ages determined in the reviewed papers were mostly based on the participants' self-reports of when their drinking became problematic, which arguably, are unreliable; self-reports tend to under-estimate alcohol consumption (Stockwell et al., 2008, 2014, 2018). Secondly, the participants' perception (in the reviewed papers) of the age when their drinking became problematic was different than that reported by many family members and friends (Finlayson et al., 1988; Schonfeld, & Dupree, 1991), who had reported much earlier ages for the onset of problematic drinking, than those reported by the participants in the respective studies. Nonetheless, the investigation of the 26 papers in the review suggested that an approximate age for late-onset AUD/problematic drinking is ≥50-years-old.

According to Greaves (2020) "substance use patterns and trends are gendered". Therefore, to fully understand and, thus, treat late-onset problematic drinking effectively, "a sex- and gender-based analysis" is required (Greaves, 2020, p. 1). There are, of course, fundamental biological gender differences to take into account (e.g., anatomy, genetics, hormones, metabolism, organ function, reproductive systems), but there are also socially constructed gender roles to consider (e.g., child rearing/caring and differing societal expectations); accordingly, the review found considerable gender differences. For example, late-onset problematic female drinkers tend to be older than their male counterparts (e.g., Christie et al., 2013; Dauber et al., 2018). Furthermore, and consistent with older drinkers in a general context (e.g., Blow, 2000; Cowart & Sutherland, 1995; Epstein et al., 2007; Green,

2006), the ratio of female problem drinkers compared to male problem drinkers, was higher among late-onset problem drinkers, in comparison to the gender ratio among early-onset problem drinkers. Interestingly, the review found that late-onset women are more likely to engage with and respond to treatment than late-onset men. Moreover, and in line with Greaves'(2020) call to action (above), the review found that it has been suggested that healthcare professionals and alcohol treatment practitioners should consider tailoring treatment programmes, so that they reflect the everyday lives of older women problem drinkers (e.g., Brennan et al., 1993).

Regarding psychosocial characteristics, co-morbid mental health challenges were present in 12 of the review's 26 papers; with a prevalence of 46%, they emerged as the most common psychosocial characteristic (and risk factor) associated with the late-onset populations in the review. Retirement was reported as the next most prevalent risk factor, present in 11 (42%) of the reviewed papers. The review found that for many people, retirement meant they no longer had access to an important social group (employment colleagues), which tended to have a negative impact on their identity (Steffens et al., 2016). Lesser psychosocial characteristics that were present in seven of the review's papers, were bereavement and family factors, both of which generated risk factors such as loneliness, isolation, boredom and a lack of MPL, factors which ultimately affect drinking behaviour (Nicholson et al., 2017; Shaw & Palattiyil, 2008). However, only two papers explicitly investigated MPL (Adams & Waskel, 1991a; Emiliussen et al., 2017c), while a further four (Christie et al., 2013; Finlayson et al., 1988; Van Montfoort-De Rave et al., 2017; Wadd et al., 2011), highlighted one of the root causes of a lack of MPL, boredom. This particular finding, emphasised the lack of knowledge that has been undertaken on the relationship between MPL and late-onset problem drinking, and further highlighted the need for more research in the area, and thus, highlighting the relevance of this thesis.

7.2.2 A summary of the findings of two qualitative studies

To identify and fully understand what differences, if any, might separate late-onset problem drinkers from the general population of problematic drinkers, the thesis' three studies used a comparative methodology (i.e., late-onset problem drinkers versus early-onset problem drinkers). Both of the qualitative studies used the same 18 participants (n = 9 early- and n = 9 late-onset) from an overall sample of 381 (n = 249 early- and n = 132 late-onset); most of the papers in the literature review had used similar comparative methodologies (both cross-sectional and prospective designs). In a more general context, there is a considerable body of qualitative research based on the narratives of people in recovery from AUD/problematic drinking, (e.g., Forcehimes, 2004; Medina, 2014; Swora, 2004; Weegmann, & Piwowoz-Hjort, 2009). These narratives typically include two 'voices': that of the 'active problem drinker' and the 'voices of recovery'. This thesis, therefore, acknowledged these two, distinct voices by dedicating a separate study to each. Importantly, the thesis recognises that the 'active' drinking voices of people in recovery are retrospective and that any data generated by the participants' narratives is likely to be affected by memory recall and self-presentational biases (Davies, 1997), and the perceived truths of the person recalling memories (Del Boca, & Noll, 2000); in contrast, self-reports of more recent events are likely to have greater accuracy (Midanik, 1982). The research questions that each study sought to address, appear at the end of either study's introduction section (for the *Active Drinking Voice*, refer to p. 110; for *Voices of Recovery*, refer to p. 157).

Overall, there was much greater divergence between the narratives of both cohorts in their 'active' drinking voices compared to their 'recovery' voices, where there was greater convergence between the voices of the two cohorts. For example, although difficulties with emotional regulation was common among both groups in the *active drinking voice* study, emotional dysregulation was more prevalent among the early-onset cohort, who were also more

likely to experience emotional dysregulation much earlier in life. In common with the findings of the literature review, the main area of convergence between both cohorts in the *active drinking voice* study, was an equally high prevalence of co-occurring mental health conditions. The impact that problem drinking has on the family is a dynamic relationship and is another central feature in the context of both active drinking (e.g., Chinnusamy et al., 2021; Johannessen et al., 2022; Orford et al., 2010) and recovery (e.g., Best et al., 2021b; Coppello et al., 2005; Edwards et al., 2018).

Problematic alcohol consumption is often associated with growing up in a family context, in which alcohol is normalised and viewed as socially acceptable (Copello, & Orford, 2002; Sawyer et al., 2018; Ward, & Snow, 2011). In the *active drinking voice* study, the family dynamic was present in the narratives of both groups but was far more prevalent in the early-onset group, whose families were more likely to normalise excessive alcohol consumption. The dynamic role of the family is an equally important feature in recovery narratives too (e.g., Jacobs, & Jacobs, 2015; McCrady, & Flanagan, 2021; Moos, & Moos, 2007; Pettersen et al., 2019), and was evident in the narratives of both cohorts in the *voice of recovery* study, as were the different family dynamics between the two groups. For instance, whereas the narratives of the late-onset cohort indicated that the participants tended to have supportive families, the narratives of the early-onset participants, indicated that their families were not only less supportive but were, occasionally, ambivalent about the participants' sobriety/recovery.

There were several characteristics in the *active drinking voice* study, that were more prevalent among late-onset participants than their early-onset counterparts. For instance, not surprisingly, late-life events as risk factors for increased alcohol consumption were associated with the late-onset group. Additionally, challenges to identity and self-concept, most often associated with career/work change (e.g., retirement), was the most prevalent risk factor among the late-onset cohort. Loss of control and dependency was a more gradual process among the

late-onset cohort, compared to their early-onset counterparts, whose transition to a state of dependence on alcohol was rapid, mostly occurring before the age of 30. It is worth noting that, according to the participants' narratives, most of the late-onset cohort in the *active drinking voice* study had drunk alcohol in a social context for many years before their drinking became problematic. However, the narratives of two of the nine qualitative late-onset participants, indicated that their alcohol consumption had been excessive for many years, with both participants claiming that their drinking became a problem when they were between 50 and 55-years-old. On one hand, this may have been their perception; the literature review, for instance, had shown that the perception of late-onset problem drinkers is not always reliable, and that family and friends often noted that drinking became problematic much earlier than the problem drinker perceived it had. On the other hand, they may have had greater (Elvig et al., 2021) or even acute (Holland, & Ferner, 2017; Martin, & Moss, 1993) tolerance to alcohol. This sub-group within the late-onset cohort will be discussed further, later on. As indicated above, there were more similarities between the two cohorts in the second qualitative study, *voices of recovery*.

For example, participants in both cohorts typically followed abstinence-based recovery pathways. Furthermore, the narratives of both groups suggest they have high levels of abstinence self-efficacy, which has been reinforced by participation in peer-based recovery support. Indeed, the study found that regardless of onset-type, reaching out to other peers, encourages and promotes abstinence self-efficacy, which was seen as essential to the participants' recoveries. However, whereas mutual-aid group membership was an important source of social recovery capital for both cohorts in early recovery, with time in recovery, late-onset participants were more likely than early-onset participants to develop broader social networks outside of their mutual-aid network. This could be because a number of the early-onset participants were A.A. members, and as discussed earlier, A.A. becomes a habitual way

of life for many people (refer to endnotes 6 and 7, p. p. 230-231). Finally, although the psychological, emotional and mental health of both cohorts improved considerably in recovery, some participants in the early-onset group still faced challenges in these three domains.

7.2.3 A summary of the findings of the quantitative study

Using an online survey, chapter six considered three of the thesis's four research questions from a quantitative perspective (for relevant research questions refer to p. 200). The study compared MPL between the two groups, and also investigated the psychosocial characteristics and recovery pathways (more correctly mutual-aid organisations) of both cohorts. Two measures were employed, specifically for the purpose of investigating MPL, the Purpose in Life test and the MLQ, while the demographic questionnaire provided the data for determining the psychosocial characteristics and (mutual-aid) recovery pathways of both groups. Onset age for late-onset AUD/problematic drinking, determined by the questionnaire data and applicable to all three studies, was estimated to be ≥45-years-old, compared to the literature review, which determined ≥50-years-old as an appropriate cut-off for late-onset. A thorough investigation of the survey data (based on the data of 381 respondents) showed that late-onset AUD/problematic drinking onset, can only ever be approximate and is most likely to emerge in a ten-year window, between the ages of 45 and 55-years-old. The study found a number of significant differences between the two cohorts. In common with many of the papers in the literature review, the study found that approximately two-thirds (65.4%) of respondents were early-onset, while approximately one-third were late-onset (34.6%). Returning to the lens of gender, there was a significant relationship between onset-type and gender. Similar to the findings from the literature review, compared to the early-onset cohort (57.8% female vs 42.2% male), there was a significantly greater proportion of women (75.8%) than men (24.2%) among late-onset respondents.

In the context of mutual-aid organisations, there were significant differences in onset-type and the organisation where recovery was found. For example, 54.2% of the early-onset respondents cited A.A. as the organisation where they found recovery, whereas only 28% of the late-onset respondents credited A.A. Moreover, compared to late-onset respondents, the early-onset cohort had significantly longer time in recovery and abstinence from alcohol (these two characteristics are associated and are discussed further, later on). Regarding the Purpose in Life test and the MLQ (comprised of two subscales, designed to measure the presence of meaning life and the search for meaning life). There were significant differences between Purpose in Life test scores and the organisation where recovery was found. Additionally, there was a significant relationship between Purpose in Life test scores and the length of time in continuous recovery; the same, significant relationship existed between the presence of meaning life and continuous years in recovery, suggesting that meaning life increases as length of time in recovery increases. Furthermore, analysis showed that there was a significant difference between the search for meaning life and onset-type. Further analysis, showed there was a negative, significant relationship between the search for meaning life and continuous years in recovery, suggesting that the search for meaning life is greater in people with less time in recovery and decreases as time in recovery increases. Interestingly, a strong, positive, significant relationship was found between Purpose in Life test scores and the presence of meaning life, suggesting that the psychological constructs of purpose in life and meaning life increase in tandem, or perhaps symbiotically. Alternatively, it may be that the scales (i.e., the Purpose in Life test and the MLQ) measure the same underlying phenomenon.

However, although a number of statistically significant differences have been reported here, in both the general context of recovery (e.g., early-onset respondents had longer time in recovery than late-onset respondents), and in relation to the Purpose in Life test and the MLQ (e.g., the search for meaning life decreases with time in recovery), there were no differences

between the two groups in their recovery, in relation to their degree of either purpose in life or meaning life. In summary, the study suggests that there are no differences in MPL scores between early- and late-onset problem drinkers in recovery, and that the degree of purpose in life and meaning life in recovery is dependent on the length of time in recovery rather than the age of onset of problem drinking.

7.3 PRACTICAL IMPLICATIONS OF THE THESIS' FINDINGS

This section considers what additions have been made to the evidence base by this thesis. The thesis was undertaken because, a) This is a unique area of alcohol harm, in which there is a scarcity of research and where additional knowledge is much needed, and b) Late-onset AUD/problem drinking has never been considered within the context of MPL (section 7.4 is devoted solely to discussing the theoretical implications). A third reason why the thesis was undertaken, was one of policy and practice. The author posits the notion that a greater awareness of late-onset problem drinkers, and older problem drinkers generally is needed, to inform healthcare professionals working in primary healthcare settings, where older patients who drink problematically are often mis-diagnosed (O' Connell et al, 2003; Tampi et al., 2019) or simply overlooked (Ayers et al., 2012; Babatunde et al., 2014). Practicalities, and weaknesses that have been identified in the current research, are acknowledged and synthesised throughout the following text.

7.3.1 Consolidating knowledge and contributing new findings to the evidence base

Some of the findings in the thesis' three studies are in agreement with the existing evidence base, much of which has already been discussed in the overview section (7.2 above). For example, the thesis reported many of the gender differences already present in existing research, e.g., there is a greater prevalence of females than males among late-onset problem drinkers, in comparison to the gender ratio among early-onset problem drinkers. Similarly, in

common with the existing evidence base, the thesis' three studies found that female late-onset problem drinkers tend to be older than male late-onset problem drinkers. Findings on gender differences are particularly useful, in the context of practice, i.e., informing healthcare professionals. Further, the findings suggest that the risk of females developing alcohol-related problems increases in tandem with age and may be related, in part, to gender-specific, socially constructed roles (i.e., child rearing/caring), which can eventually lead to psychological and emotional challenges such as empty-nest syndrome (Allan, & Cooke, 1985; Bougea et al., 2019; Kaur, & Kaur, 2021; Kougiali et al., 2021; Mitchell, & Lovegreen, 2009; Plant, 2005), which is more likely to adversely affect women than men, at a time when their primary female identity of being a mother is challenged, after their children leave home.

Discussed above, and throughout, the thesis' three studies have avoided using the stigmatising language that often accompanies addiction discourses, and which is likely to affect women far more than it does men. It should be pointed out, however, that until relatively recently, using a softer, less stigmatising language does not appear to have been a consideration in the literature, even though stigmatising terminology such as 'alcoholic/alcoholism' were dropped and the term, alcohol use disorder (AUD) was introduced in the DSM III (APA, 1980) over forty years ago. That said, because of its obvious association with alcohol and to a lesser degree problematic drinking, it could be argued that the term AUD could itself be viewed as stigmatising (Kelly et al., 2016). Nonetheless, many of the papers in the literature review used stigmatising language (e.g., alcoholics, alcohol abusers). Moreover, and mentioned earlier in the literature review, and importantly in the context of clinical practice, stigmatising language can affect the decision making of healthcare professionals (Ashford et al., 2019).

With the exception of the late-onset group in the second qualitative study, emotional dysregulation was found to be a central feature of both of the thesis' qualitative studies, yet only three papers in the literature review investigated and discussed emotions (Brennen et al.,

1993; Brennen & Moos, 1990; Dupree at al., 1984). The author posits the notion that emotional dysregulation, an inability to regulate and manage emotions, is a common characteristic, not only of older problem drinkers, but problem drinkers in a general context; there is a body of evidence to support such a claim (Cservenka et al., 2014; Kornreich et al., 2013; Kurtz, 2002; Oscar-Berman et al., 2014). As such, emotional dysregulation should be recognised as a common characteristic of 'active' late-onset problem drinkers. Indeed, many years ago "a group of eminent psychologists and doctors" who studied a large group of problem drinkers, concluded that the majority of problem drinkers investigated, "were still childish, emotionally sensitive and grandiose" (A.A., 1953, p. 127). Here, the adjective 'childish' and the phrase 'emotionally sensitive' can be compared to emotional dysregulation, which is relatively contemporary diagnostic terminology (Miller et al., 2006). Emotional dysregulation is a part of the broader area of mental health.

The literature review showed that one of the leading characteristics among late-onset problem drinkers is a high prevalence of poor mental health. However, it is important to emphasise that the high prevalence of poor mental health is not solely restricted to late-onset problem drinkers and is a highly prevalent characteristic among problem drinkers generally. That people with poor mental health use alcohol as a coping mechanism (Khantzian, 1997), coupled with the evidence that declining mental health is associated with increases in alcohol consumption (Bell & Britton, 2014), suggests a mutually generative and supportive relationship between poor mental health and excessive alcohol consumption (Puddephatt & Goodwin, 2019). By confirming a high prevalence of poor mental health among its participants, the findings of the qualitative studies support the existing evidence base. Indeed, the high prevalence rates of mental health problems among people with AUD/problem drinking generally, has meant that a mutual-aid organisation to support people with comorbid mental

health and alcohol and other drug problems has emerged, i.e., Dual Diagnosis Anonymous (DDA), with a presence in the UK (Milani et al., 2020, 2021).

Age of onset was discussed thoroughly in the 'overview' section above and was a prominent feature throughout the thesis. As far as can be ascertained, until the approximate late-onset age of ≥50-years-old, suggested by the thesis' literature review, there does not appear to have previously been any degree of agreement on the age of late-onset. Rather, there has been a wide range of onset ages along with several temporal categorisations, other than early- and late-onset (e.g., early- or mid-age-onset, midlife-onset, quasi-late-onset and very-late-onset). This plethora of onset-ages and categorisations is impractical, extremely unhelpful and confusing to healthcare professionals. Additionally, healthcare professionals also have to take into consideration important gender differences (i.e., females tend to seek-help later than men). Furthermore, the sub-category in the late-onset cohort in both of the qualitative studies, who had reported drinking heavily for a considerable time before their drinking became problematic, adds further confusion, and even lends credibility to the idea that AUD/problem drinking may be a simple continuum, rather than categories of onset-types based on age.

As such, it may be helpful to base onset of problematic drinking on the individual's first help-seeking episode, rather than their subjective perception of when their drinking became problematic, which is typically contradicted by other interested and concerned parties (family and friends). That said, the findings of the thesis' three studies, along with the literature review's findings, has contributed a substantial amount of evidence to an existing body of research that fully supports the notion of two temporal categories of problem drinkers: early- and late-onset. As discussed previously, age categorisations in this area of alcohol harm, can only ever be approximations. The point is, they are practical approximations, that can act as a 'window in time', that may be helpful in informing healthcare professionals in their considerations and decision making (Dar, 2006; DiBartolo, & Jarosinski, 2017). Finally, the

quantitative study's findings that late-onset AUD/problem drinking is most likely to emerge in a ten-year window, between 45 and 55-years-old, is in line with the literature review's estimated late-onset age of ≥50-years-old.

7.4 THEORETICAL IMPLICATIONS

In the context of MPL, the thesis' findings have made a considerable contribution to the late-onset evidence base. For example, in the quantitative study, statistical tests of both the Purpose in Life test and the MLQ reported significant findings. As the thesis' chosen theoretical framework, Frankl's (1963) theory of meaning (logotherapy), has been a connecting thread throughout the thesis. This section follows the thread across the thesis' chapters; it is not another discussion on the theory of logotherapy, per se, which has already been thoroughly and comprehensively discussed. Chapter three, for instance, considered logotherapy's origins and its ontological and epistemological positions, while the introduction to the previous chapter included a summary of the theory, noting that the spiritual dimension of human experience is at the heart of logotherapy. The spiritual dimension is considered by many scholars of logotherapy (Kimble, & Ellor, 2001; Leontiev, 2016; Marseille, 1997; Wong, 2014) to be fundamental in addressing Frankl's existential vacuum concept, i.e., boredom, ennui and an apathetic attitude towards life. The theoretical thread began in chapter one's introduction and continued through to the literature review (chapter two).

7.4.1 Following the theoretical thread

The links between MPL and recovering from addiction, have been acknowledged by a body of research over a considerable period of time (e.g., Carroll, 1993; Crumbaugh, 1981; Gerwood, 1998; Granfield, & Cloud, 1999; Henrion, 1987; Hutzell, 1984; Jacobson et al., 1977; Oakes, 2008; Panel, T.B.F.I.C.P, 2007; Waisberg, & Porter, 1994). To date, however, MPL has been used sparingly as an investigative theoretical framework, in the context of late-onset

AUD/problem drinking; Adams, & Waskel (1991a), who focussed specifically on MPL (refer to literature review) is an exception. (Re)discovering MPL, however, is widely recognised as an integral component of many recovery pathways (Krentzman et al., 2015; Roos et al., 2015; SAMSHA, 2012; UNODC, 2008; White et al., 2006; WHO, 2020). Because of the dearth of research on MPL in late-onset problem drinkers, this thesis' literature review (published, McInerney et al., 2023) has already made a positive contribution to the discussion. As noted above, the theoretical thread continued through chapter three, in the form of a theoretical overview, and then through to the first of the thesis' three studies in chapter four, the 'active drinking voice'.

Chapter four did not focus on MPL, per se, rather, the chapter addressed the first of the thesis' four research questions: *Investigate and compare the psychosocial characteristics of late-onset problem drinkers in recovery and the psychosocial characteristics of early-onset problem drinkers in recovery when both cohorts were drinking*. That said, one of the three hypotheses posed in the methodology chapter (refer to chapter three, p. 80), is theoretically relevant, in part: *It was hypothesised that MPL would be a more prominent feature in the discourses of early- and late-onset drinkers in recovery, compared to when both cohorts were drinking*. Indeed, a *lack* of MPL featured prominently in the participants' narratives in chapter four, in contrast to the '*voices of recovery*' (chapter five), in which the presence of MPL was the prominent feature. Therefore, the participants' discourses in both studies, from different perspectives, supports the hypothesis. One of the thesis' basic theoretical premises was that late-onset drinkers may begin to drink problematically because they experience an existential vacuum, following major events that occur later in life (e.g., retirement, challenges to identity). The *active drinking voice* study (chapter four), however, showed that the existential vacuum (a lack of MPL), was equally present in the early-onset participants. Of course, chapter four's findings do not necessarily imply that seeking recovery is a consequence of MPL.

That all problem drinkers, regardless of onset-type, experience a lack of MPL, when they are actively drinking, has been acknowledged by a body of research in this area (Crumbaugh, & Carr, 1979; Nicholson at al., 1994; Waisberg, & Porter, 1994). Moreover, a lack of MPL in different age groups of problem drinkers is associated with different psychological factors (Kleftaras, & Katsogianni, 2012). For example, and in support of the thesis' premise (reiterated above), late-onset participants in the *active drinking voice* study were far more likely to be affected by challenges to identity than the early onset participants (refer to *Appendix 4.6* and *Appendix 4.7*, Personal Experiential Themes). Following the theoretical thread, the *voices of recovery* (chapter five), investigated MPL directly, by addressing one of the research questions: *Explore and compare the role of MPL, between early- and late-onset problem drinkers, who are in recovery*.

As hypothesised, it was evident in the *voices of recovery*, that MPL was a more prominent feature in the narratives of both cohorts, than it had been when they were drinking. Moreover, throughout, the thesis' studies have suggested that high levels of abstinence self-efficacy (DiClemente et el., 1994) can be extremely beneficial to people coming into recovery, something that was evident in the discourses of both cohorts. Abstinence self-efficacy was described earlier as the 'adaption and application of Bandura's (1977) original self-efficacy concept, to alcohol abstinence'. Song et al. (2018) found that abstinence self-efficacy is mediated by purpose in life, suggesting that purpose in life is an important construct in recovery from problematic drinking. Furthermore, abstinence self-efficacy is essential in supporting people in recovery to achieve and maintain abstinence, which in turn, gives the individual a purpose in their life, a goal to aim for (Krentzman, 2017; Mowbray et al., 2013). Chapter five showed that one other element was an essential component in supporting the participants' in their recoveries, peer-based recovery support; this completes a dynamic triad of recovery support mechanisms, abstinence self-efficacy, peer-based recovery support and MPL. The

following section, discusses and explores the role of this important triad of recovery support mechanisms, which were evident in the 'recovery narratives' of all 18 participants in the qualitative chapter (early- and late-onset), with a particular focus on the relationship between peer-based recovery support and MPL.

7.4.2 A dynamic triad of recovery support mechanisms: abstinence self-efficacy, peer-based recovery support and MPL

The findings of the '*active drinking voice*' study (chapter four) showed that there was a great deal of heterogeneity between the psychosocial characteristics of both cohorts when they were still drinking. However, there was a major point of convergence, in a shared co-morbidity of poor mental health. Arguably, both groups shared another characteristic when they were actively drinking, i.e., a lack of MPL. In contrast, the psychosocial characteristics of both groups in recovery were extremely homogenous. Abstinence self-efficacy, peer-based recovery support and MPL, for example were present in both the personal experiential themes and the group experiential themes of both groups (*Appendices 4.6, 4.7, 4.8, & 4.9*). All participants had chosen abstinence-based recovery pathways and all had experienced or were still engaging with peer-based recovery support, via either mutual-aid organisations or groups based in community services. Additionally, all participants experienced a greater degree of MPL, attributable to either peer-based recovery support or social support, or both.

For many, though not all problem drinkers, achieving abstinence may be the first worthwhile goal they have achieved, or at least worked towards, for a considerable time. Abstinence represents having a goal to strive for; it gives one's life purpose, sometimes if only for short periods. Interestingly, problem drinkers whose goal is abstinence, tend to show greater day-to-day efficacy in early recovery (Dunn, & Strain, 2013; Treloar Padovano et al., 2022) and have better treatment outcomes (Bergland et al., 2019) than people whose chosen goal is moderation, suggesting that having abstinence as a goal rather than moderation may be

indicative of a greater sense of purpose. Furthermore, the evidence supports the notion that many individuals in early recovery, even those with high levels of abstinence self-efficacy, tend to need the support of a social network (Best et al., 2011b; Best et al., 2015; Best et al., 2017; van Melick et al., 2013), which will almost certainly include the peer-based recovery support model (Ashford et al., 2019; Best et al., 2022; Krawczyk et al., 2018; Tracey, & Wallace, 2016; White, 2009; White et al., 2012). Peer-based recovery support as a model of recovery from alcohol dependence, can be traced back, at least to the first half of the nineteenth century (over 180 years ago), to the mutual-aid prototype, the *Washingtonian Total Abstinence Society*[2] (noted briefly in chapter four), and probably much further (refer to White, 2009).

Typically, peer-based recovery support is a part of the mutual-aid organisation model of recovery, which, in the UK, encompasses lived experience recovery organisations (National Institute for Health and Care Research [NIHR], 2023). Lived experience recovery organisations are run independently by and for people in recovery from problematic substance and alcohol use. As well as the psychological and therapeutic aspects of recovery, lived experience recovery organisations offer support in other areas, including peer mentoring, employment training and social activities. Additionally, peer-based recovery support is now widely recognised by the UK government (Gov. UK., 2023), non-governmental organisations (NGOs) and charitable trusts with a presence in the field of recovery from alcohol and other drugs, as an integral part of recovery support services (RSS; Beales, & Wilson, 2015; Kulik, & Shah, 2016) and UK CDAS alcohol services (Best et al., 2021a). People in recovery, in either voluntary roles, or increasingly, in paid employment within such services are generally referred to as ‘people with lived experience’, ‘lived experience practitioners’ or ‘experts by experience’. peer-based recovery support is a reciprocally dynamic construct, that is beneficial to both the recipient of support and the donor (the person giving support). White (2009), offers the following definition of peer-based recovery support “as a starting point for discussion”:

> *Peer-based recovery support is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from severe alcohol and/or other drug-related problems. This support is provided by people who are experientially credentialed to assist others in initiating recovery, maintaining recovery, and enhancing the quality of personal and family life in long-term recovery.* (p. 16)

The first sentence in White's (2009, p. 16) "starting point for discussion", succinctly defines the peer-based recovery support process. The second sentence, however, arguably misses two fundamental characteristics of peer-based recovery support. The first of these being *identification*, a dynamic that is dependent on both parties (peers) being able to 'identify' and empathise through the commonality of their shared experiences; this is *the* fundamental component through which peer-based recovery support functions. It could be argued that the term "experientially credentialed" encompasses *identification*, but the correct language is important. In the context of recovery, the phrase "experientially credentialed", does not hold the same meaning as *identification*, which implies a deeper, and more human connection. The second and perhaps less obvious omission in White's definition of peer-based recovery support is the reciprocal benefit to the peer supporters (those that give support).

Peer supporters help their peers because, a) it gives their life a purpose, and b) in doing so, it reinforces their own sobriety and recovery. Schwartz, & Sendor (1999) found that peer supporters experienced improved "self-efficacy, life satisfaction and purpose in life" (p. 1568); similarly, Barker et al. (2018) found that peer supporters felt that helping others, supported their own recovery and sobriety, by making them feel they are useful and "have purpose, and lead meaningful lives" (p. 224). Moreover, Barker and Maguire (2018) have suggested that peer-to-peer relationships have the potential to motivate "behavioural and cognitive changes", similar to the mechanisms of behaviour change that occur in the therapeutic relationship in

psychotherapy (p.609). The dynamic relationship between the triad of recovery support mechanisms (abstinence self-efficacy, peer-based recovery support and MPL), and also the transformative and reciprocal process of 'identification', can be found in A.A. founder, Bill Wilson's story (A.A., 1985), which is also an exemplar of A.A.'s twelfth-step[3]. In short, Wilson found that the experience of trying to help another problem drinker, is a reciprocal one. That is, not only is the process an expression of empathy for another human being, but on both a practical and spiritual level, the experience reinforces one's own sobriety/recovery (see *Appendix 7.1*). His experience highlights the dynamic relationship that occurs between the triad of recovery support mechanisms and suggests how the "behavioural and cognitive changes", posited by Barker and Maguire (2018, p. 609), may actually work.

7.4.3 Differences in MPL between early- and late-onset drinkers diminish in recovery

Chapter six addressed three of the thesis' research questions, one of which was also considered in chapter five (cited above, p. 248); the question maintains continuity of the theoretical thread, by directly investigating MPL in both cohorts of problem drinkers. This sub-section considers the broader meanings of the results discussed in section 7.2.3. For instance, *it was hypothesised that, regardless of onset-type, there is an association between the degree of MPL in individuals in recovery and their length of time in recovery*. The results supported the hypothesis, finding that the level of MPL in people in recovery is not dependent on onset-type, rather, the degree of MPL a person has in recovery, correlates with their length of time in recovery. That said, a significant difference was found between the search for meaning life and onset-type, which suggested that the late-onset respondents were more likely to be searching for meaning life than early-onset respondents. However, closer investigation shows that the result can easily be mis-interpreted. That is, the result is not based on onset-type per se. Rather, it too, correlates with length of time in recovery; the mean age of years in recovery for early-onset respondents (m = 12.71 years-old) was almost four times greater than the late-onset respondents mean age

of years in recovery (*m* = 3.27 years-old). These findings provide evidence that people in recovery are searching for meaning.

The findings in chapter six also showed, that as the degree of purpose in life increases in recovery, so too, does the presence of meaning life. Theoretically, these findings imply that the lack of MPL (existential vacuum) that was evident in the participants' 'active drinking' discourses in chapter four diminishes and confirms that MPL increases as time in recovery increases. Furthermore, the findings in chapter five and chapter six, suggest that the difference in MPL between the early- and late-onset cohorts, that was evident in chapter four when both groups were drinking, diminishes with time in recovery. Additionally, the evidence in chapter six also showed there was a significant relationship between onset-type and the mutual-aid organisations that respondents had credited with finding recovery, which in part, answers another of the research questions addressed in chapter six: *Investigate and compare the recovery pathways of late-onset AUD/problem drinkers and early-onset AUD/problem drinkers*. The results showed that almost twice as many early-onset respondents (54.2%) credited A.A. as the organisation where they found recovery, compared to late-onset respondents (28.8%). How can such a wide variance in choice of mutual-aid organisation be accounted for?

7.4.4 Differences in choice of mutual-aid recovery pathways between onset-type

At the time the study in chapter six (*Having a purpose in life and finding meaning*) was undertaken, 110 (44%) of the 249 early-onset respondents had been in recovery between 10- and 52-years. 69 (28%) of these had been in recovery between 20- and 52-years, 16 (6%) had been in recovery between 15- and 19-years, and 25 (10%) had been in recovery between 10- and 14-years; 93 of these (37% of the total early-onset cohort) credited A.A. as the organisation where they found recovery. The remaining 139 early-onset respondents, had been abstinent and in recovery between one and nine years (refer to *Appendix 7.1., Participants' Organisation,*

Years in Recovery and Onset-type), and 40 of those (16% of the total early-onset cohort), had reported A.A. as the organisation where they had found recovery. Therefore, it is a reasonable assumption, that at the time they began their recovery, the 34% (85) of early-onset respondents who reported being in recovery between 15- and 52-years and who credited A.A. as the organisation where they found recovery, there were few (if any) alternative mutual-aid organisations, other than A.A. to choose from. Walter's (2002) critique of A.A highlighted the dearth of mutual-aid choices and presented twelve reasons why alternatives were needed for the many people for whom A.A. is "inappropriate and ineffective", and "who find A.A. principles or practices objectionable" (p. 53).

More recently, however, A.A. no longer has a monopoly in the area of mutual-aid support and a number of alternative organisations have emerged and continue to evolve. SMART Recovery, for instance, has been in the UK since 2009[4]. And 13 years ago (at the time of writing), Groshkova and Best (2011, p. 20) referred to an "increasing interest and activity at the community level in self-help, mutual-aid, and the emergence of *communities of recovery*", e.g., 'The Well Communities' (founded in 2012) and founding member of the lived experience recovery organisations referred to above. Additionally, the burgeoning online presence of mutual-aid recovery organisations, evidenced in the research in this thesis (see *Appendices 3.5 & 6.4*), can reasonably be viewed as a 'game changer'. It has meant that people are no longer faced with geographical limitations regarding their choice of mutual-aid organisation. Of course, in the context of the research undertaken in this thesis, it is also worth bearing in mind that mutual-aid alternatives to A.A. have arguably had a presence for much longer in North America (USA & Canada) than they have in the UK. Nonetheless, that 72 (54%) of late-onset respondents were more likely to have a preference for alternative mutual-aid organisations, is possibly a reflection of the evolutionary change in recovery options available in the UK and internationally.

Just eight late-onset respondents (6% of the total late-onset cohort) had been in recovery for more than ten years (compared to 44% of the early-onset respondents); five of these credited A.A. as the organisation where they found recovery. For the remaining 100 (75% of the total late-onset respondents), all of whom were relatively new to recovery (between one and three years), the proliferation of mutual-aid groups that has emerged in the last two decades, has meant that many people who came into recovery during that time, had a much greater choice of mutual-aid options to choose from. The '*other*' organisation category in chapter six, for example, is comprised of 28 alternative mutual-aid organisations (refer to *Appendix 7.1, Participants' Organisation, Years in Recovery and Onset-type*), many of which have an online presence only. Despite its position as the dominant mutual-aid organisation globally, A.A. has its limitations and does not work for everyone, which A.A. acknowledges[5], "Upon therapy for the alcoholic himself[6], we surely have no monopoly" (A.A., 2001, p. ix). Many problem drinkers (Kurtz, 2010; Lopez Gaston et al., 2010; McClure, & Wilkinson, 2020), as well as health care professionals (Kelly et al., 2006; Winzelberg, & Humphreys, 1999), for instance, view A.A. as a quasi-religious movement, and a growing number of its members are leaving A.A., dissatisfied and disillusioned with controlling and bullying behaviour, as well as "their objections to the religiosity that is deeply embedded within A.A. ideology" (Glassman et al, 2022b, p. 421). According to Ogborne (1989), A.A. has greater efficacy on problem drinkers who have a particular set of characteristics, including a history of heavy drinking, loss of control and "signs of religiosity and authoritarianism" (p. 55).

A summary of the mutual-aid landscape, shows that for over 60 years, from its creation in 1935, A.A. had been the only mutual-aid/P-BS organisation available to problem drinkers seeking help and support in recovery; there were, simply, no alternatives. However, towards the end of the twentieth century, other mutual-aid recovery organisations began to emerge (e.g., Secular Organisations for Sobriety [SOS]; SMART Recovery [formally Rational Recovery]).

Moreover, A.A.'s 12-step model has been almost universally repurposed by treatment programmes in the US, as the *Minnesota Model* (refer to end note 7), and also adopted by the US criminal justice system, where people with alcohol and other drug problems are mandated to attend A.A. meetings, and other 12-step organisations, as a part of their sentence (Dodes, & Dodes, 2015). A.A.'s dominant position in the area of recovery may have been further aided by A.A.'s influence on the National Council on Alcoholism and Drug Dependence[7] (NCADD; Peele, 1995; Pop, 2010). It is important to highlight the eclectic choices of mutual-aid organisations available to people entering recovery nowadays, compared to the limited choices that were available to people who are now in long-term recovery. Furthermore, the literature review's finding that late-onset problem drinkers are more treatment compliant and have better treatment outcomes than early-onset drinkers, is something that impacts on mutual-aid recovery pathways for both groups and is discussed in the next section.

7.5 IMPLICATIONS FOR RECOVERY

7.5.1 Late-onset problem drinkers: the role of RC

The literature review at the beginning of the thesis, identified three recovery-related themes that appeared, in varying degrees, throughout the review. 1) — *Greater access to RC leads to improved outcomes for late-onset drinkers*[8] (found in 14 papers). 2) *Bespoke, age-specific treatment programmes are beneficial for LO problem drinkers* (present in 17 of the review's 26 papers). 3) — *Late-onset problem drinkers are more treatment compliant than early-onset problem drinkers* (apparent in just over a third [9] of the papers). This section considers these themes in the context of the findings of the thesis' three studies, and recovery generally. The first and the third themes cited above are closely related; that is, compliance (recovery efficacy) is dependent, in part, on the degree of RC available to the person entering recovery.

For example, in common with the late-onset cohorts in many of the review papers (e.g., Atkinson et al., 1990, 1985; Dauber et al., 2018; Emiliussen et al., 2017a, 2017b, 2017c; Van

Montfoort-De Rave et al., 2017; Wadd et al., 2011), both of the thesis' qualitative studies suggested that the late-onset respondents had greater reserves of RC to draw on than their early-onset counterparts. The late-onset participants, for instance, were likely to have more supportive families. Indeed, in the 'voices of recovery' study, many of the late-onset participants viewed recovery as a 'family journey', which typically, is a 'shared' journey. This may be, in part, because many of the late-onset participants had retained strong ties and close relationships with their families. Moreover, the late-onset participants developed broader social networks outside of their peer-based recovery support support networks, which in turn can lead to greater MPL (Steptoe, & Fancourt, 2019). It is important to highlight, however, that the late-onset sample in this thesis had not yet reached advanced ages, when social networks wane, SC diminishes and the consequential social isolation can have a major impact on the mental and physiological health of many older people (Schutter et al., 2022).

MPL and peer-based recovery support are two domains of RC that have already been discussed thoroughly in this chapter. It was noted that both early- and late-onset participants in the thesis' three studies tended to experience equal degrees of MPL in recovery. Similarly, peer-based recovery support was found to be equally important to, and present in both groups of problem drinkers in recovery. Family and social support, another one of the eight RC domains identified by UNODC (2008), was prominent in the narratives of the participants in both qualitative studies. A review of older problem drinkers in a general context, recommended that interventions based on "a family-oriented approach", including the wider social network of friends may be the most effective form of treatment for older problem drinkers (Stelle, & Pearson, 2007, p. 43). However, as highlighted above, advancing age means that many older problem drinkers can become isolated (Gilson et al., 2017; Wood, 2007) and detached from their family and friends (Iparraguirre, 2015). Therefore, Mulford's and Fitzgerald's (1992) note that, "it will be as difficult to develop a treatment that works for all older problem drinkers as

it has been to find one that works for problem drinkers of all ages" (p. 609/610), maybe a more realistic position to assume. Nonetheless, families, potentially, have a considerable role to play in the context of older problem drinkers in recovery.

For instance, the 'active drinking voice' study found that the early-onset cohort were more likely than the late-onset cohort to have grown up in a family where heavy drinking was normalised. Whereas, as previously noted, in the 'voices of recovery' study, the late-onset cohort were more likely to have greater resources of (social) RC, in the form of family and friends (also refer to the discussion section of chapter five, 'The family in recovery', pp. 188). The findings from both studies, in the context of family, are similar to those from the literature review. That is, compared to their early-onset counterparts, late-onset problem drinkers are less likely to come from families where heavy drinking is normalised (Atkinson et al., 1990), and were more likely to have greater support from family and friends (Brennan, & Moos, 1991; Emiliussen et al., 2017a, 2017b). Additionally, late-onset problem drinkers are more likely than early-onset problem drinkers to receive greater encouragement from their families, to seek help and enter treatment (Emiliussen et al., 2017a, 2017b).

7.5.2 Late-onset problem drinkers: help-seeking and treatment

Approximately one-third of respondents (123; 32.3%) in the quantitative study had been in formal residential treatment programmes. The percentile among each group, who had been in treatment was similar to the overall sample percentile: 33.4% of the early-onset cohort, and 30.3% of the late-onset cohort. Closer inspection of the data supports previous findings, which suggest that late-onset problem drinkers respond better to treatment than early-onset drinkers (e.g., Dauber et al., 2018; Wadd et al., 2011; Wetterling et al., 2003). The differences between onset-type regarding multiple times in treatment, for example, showed that 17.7% of early-onset respondents had been in treatment more than once, compared to 10.6% of late-onset respondents. However, the relationship between onset-type and being in treatment on multiple

occasions was not significant (x^2 = 3.49, df = 1, p = 0.62). Findings from chapter six in the context of gender should be considered cautiously, as there was a strong gender bias in the survey response rate; approximately twice as many females (64%) as males (36%) completed the survey. As such, statistical analysis regarding the relationship between gender and treatment was not undertaken. However, the body of research in this area suggests that the stigma (Wadd et al., 2011), shame and guilt (Lisansky Gomberg, 1988) associated with problematic drinking, means that older women problem drinkers are less likely than their male problem drinkers to seek help (Pretorius et al., 2009) and enter treatment (Blow & Barry, 2002; Green, 2006).

Regardless of gender differences, discussions concerning appropriate treatment pathways for late-onset and older problem drinkers generally, may be a distraction from the broader, and arguably, more important area of ongoing, stable recovery. Moreover, that 70% of the late-onset respondents in chapter six had never been in treatment, lends support to a 'natural recovery' paradigm (Best, 2019; Best et al., 2019; Cloud, & Granfield, 1994, 2001). Of course, there will always be a proportion of dependent, older problem drinkers, for whom formal treatment is an essential and necessary first step (e.g., Fingerhood, 2000; Sattar et al., 2003; Seddon et al., 2022). It could be further argued then, that many of the 17 papers in the literature review, who recommended developing bespoke "prevention programmes" (Emiliussen et al., 2017c, p. 981), "tailored" (Dauber et al., 2018, p. 7) and "specialised treatments" (Emiliussen et al., 2017b, p. 11), for older late-onset problem drinkers, were solely concerned with those individuals at one end of the late-onset spectrum who needed treatment, instead of the majority of late-onset problem drinkers, who are able to recover without the need for formal treatment. Indeed, the authors of a programme developed specifically for older problem drinkers (included in the review), *The Gerontology Alcohol Project* (Dupree et al., 1984, p. 516), emphasised that their programme was based on individuals developing "self-

management" and "psychosocial skills" to help maintain "effective social support networks", which can reasonably be interpreted as social recovery capital, in the form of friends and family, mutual-aid and peer-based recovery support. Regardless, the more pressing issue, concerning the recovery needs of many late-onset problem drinkers are, arguably, either being overlooked, or are not being detected.

7.6 CONTRIBUTIONS

The focus of much of this chapter has been on presenting the findings that each of the thesis' three studies, and the literature review, have contributed to the area of late-onset problem drinking, and considering how each of these four constituent parts addressed a number of research questions. In this section and the subsequent two sections (7.7 and 7.8), the focus moves away from the minutiae of the thesis' individual components and specific research questions, by taking a broader, more holistic, investigative lens. The text, so far, has shown that by sharing a common sample of participants, the three studies and the subsequent data are already interconnected. This section presents and synthesises the 'wholeness' created by that interconnectivity. For instance, what knowledge and evidence has the thesis, as a whole, contributed to the phenomenon of late-onset problem drinking and recovery in this specific population? The broader contributions and implications of the thesis in the context of practice and policy are also considered. Additionally, limitations of the thesis are acknowledged before concluding with suggestions for ongoing investigations into late-onset problem drinking, a much under-researched area of alcohol harm.

7.6.1 Viewing late-onset problem drinking through the lens of MPL

Arguably, the thesis' most important overall contribution to the subject area, has been the decision to investigate late-onset problem drinking from the perspective of Frankl's theory of meaning: logotherapy, which, as far as can be ascertained, has not previously been used as a theoretical framework to investigate the phenomenon of late-onset problem drinking. The relationship between MPL and problematic drinkers, both early- and late-onset, has been fully investigated throughout the thesis. To that end, the evidence that emerged in the body of the thesis showed that when both early- and late-onset problem drinkers were actively drinking, they experienced a lack of MPL. Of itself, the finding that the negative consequences associated with out of control, problematic drinking, are accompanied by feelings of apathy and emptiness, and a lack of motivation and purpose in life (i.e., existential vacuum), is neither revelatory nor surprising. After all, the relationship between older adults who consume alcohol excessively, and negative mental health conditions, particularly anxiety and depression, is supported by a great body of work (Keyes et al., 2019; Mowbray et al., 2017; Rao, 2021; Rao et al., 2019; Sacco et al., 2015) and is something that has been thoroughly investigated and confirmed by the work undertaken in this thesis.

Neither is it surprising that there was a demonstrably greater presence of MPL in both cohorts in recovery; this again, is a relationship that is supported by a broad body of research (e.g., Best et al., 2021c; Csabonyi, & Phillips, 2020; Waisberg, & Porter, 1994; Witkiewitz et al., 2021), as well as being viewed as an essential domain in leading conceptual models of recovery, e.g., CHIME [Connectedness, Hope, Identity, Meaning and Empowerment] and RC. Regardless, using logotherapy as a theoretical framework, highlights the central role that MPL plays in the lives of late-onset problem drinkers. Additionally, and discussed in detail above (p. 247), the thesis identified, what the author has termed as, **'a dynamic triad of recovery support mechanisms: abstinence self-efficacy, peer-based recovery support and MPL'**.

Together, these three psychological constructs have a mutually supportive relationship, and were found to have a positive effect in supporting and maintaining recovery from problematic drinking. Recognising the dynamic relationship between these three recovery support mechanisms, can have positive implications in practice. Therefore, further investigations are needed to better understand the relationship between this triad of recovery support mechanisms and the possible underlying mechanisms linking them. Arguably, to a lesser degree, the thesis has highlighted how the stigmatisation associated with problematic drinking affects older problem drinkers in particular, and accordingly, used a softer, more inclusive and less stigmatising language, something that is highly relevant in practice, discussed in the next sub-section.

7.7 PRACTICE AND POLICY: Informing Healthcare Professionals

At this point, it seems appropriate to go full circle, so to speak, and repeat one of the thesis' primary aims, which appeared in the thesis' introduction, at the end of the opening paragraph on page one:

> *It is hoped that the thesis' findings will inform the health and social care professionals who are most likely to come into contact with this unique population, whom the Royal College of Psychiatrists' (RCPSYCH, 2018) have described as 'invisible'.*

For the sake of accuracy, the RCPSYCH report, 'Our Invisible Addicts' (RCPSYCH, 2018), refers to the population of older people experiencing problems with alcohol and other drugs in a general context. The RCPSYCH (2018) report, originally published in 2011 and regularly updated, recommended that routine health checks for people of 65-years-old and older, should include screening for alcohol and other drugs. However, as people age, their social roles change (e.g., child rearing/care, employment) and they have less of a social presence; consequently, older adults in the UK who are drinking problematically are less likely to be identified (Holley-

Moore, & Beach, 2016). Additionally, public health campaigns tend to focus on younger cohorts of problem drinkers. Combined, all of this means that problematic alcohol consumption in older adults in the UK is either being under-detected or misdiagnosed (Taylor et al., 2014). Moreover, drug and alcohol services specifically for older people are limited. Wadd et al. (2011), for instance, were only able to identify five alcohol and other drug agencies with a service specifically designated to older people (three in England, and one each in Northern Ireland and Scotland). Wadd and colleagues' (2011) findings suggest that fewer than 1% of the alcohol services in England operate an older people's service. More recently, Crome and Crome (2018) reported that the scarcity of alcohol and other drug services specifically purposed for older people in the UK, meant that just 7% of older adults in need of treatment for problem drinking were able to be seen in them.

Even though appropriate, age-related services have been recommended by clinicians who work specifically with older populations in this area (e.g., Rao, 2011), they remain, dangerously under-resourced. In primary care settings, for example, alcohol is currently not viewed as a priority (Madden et al., 2023); indeed, the latest report on alcohol treatment services, managed by The Department for Health and Social Care (DHSC), concluded that, "We are concerned that the Department is not taking alcohol harm sufficiently seriously" (Parliament. House of Commons, 2023, p. 5). In an age of governmental-directed austerity, estimated to have reduced public spending by half a trillion pounds, in the years between 2010-2019 (Progressive Economy Forum [PEF], 2023), this is not surprising. This is despite the National Institute of Clinical Excellence (NICE), recommending (since 2010) that all adults be screened for harmful levels of alcohol consumption (NICE, cited in Mansfield et al., 2019).

According to Mansfield and colleagues (2019), the NHS health check which includes the Alcohol Use Disorders Identification Test (AUDIT), should be offered to all adults in the UK between the ages of 40 to 70, the age range that accounts for the majority of the population

being investigated in this thesis. However, Mansfield et al.'s (2019) research concluded that half of the adults registered in UK primary care settings "have no recorded alcohol consumption data" (p. 1). Furthermore, Bareham et al. (2021, p. e762) have reported that there are "clear opportunities to support older people in primary care to make healthier decisions about alcohol" and have recommended training for healthcare professionals working in primary care settings, so that they are able to identify alcohol-related harm in older patients. Additionally, Bakhshi and While (2014) have suggested that trained nurses, already working in the community, are in the ideal position to screen and detect problematic drinking in older adults in the community and direct them to the relevant services (including mutual-aid organisations). Perhaps then, the solution to addressing alcohol harm in older people, and late-onset problem drinking, is not in bespoke, age-related treatments, which address approximately just a third of the population being investigated. Rather, the solution lies, in part, in being able to identify and treat older problem drinkers in primary healthcare and community settings. This will require training for healthcare professionals who work in community and primary healthcare settings and, importantly, providing sufficient finances to make sure they are equipped with the necessary resources, so that they can address and treat late-onset problem drinkers effectively.

7.8 LIMITATIONS AND RECOMMENDATIONS

7.8.1 Limitations

The design of the thesis' three studies, meant that the dynamic differences between the lack of MPL during active drinking and its presence in recovery was not fully tested. This is because all the respondents (early- and late-onset) were in recovery, and the data presented in the thesis relating to the 'active drinking' phase was retrospective and dependent on the accuracy of the respondents' memories of past events, the reliability of which is questionable. According to Davies (1997) for instance, "memories are always acts of construction at some level" (p. 94);

reliable and accurate recall depends on, among other things "the demand characteristics of the study and the motivational state of the person doing the remembering" (p. 93). Moreover, cognitive mechanisms involved with episodic memory will have been heavily affected by excessive alcohol consumption (e.g., Pitel et al., 2007; Söderlund et al., 2007), meaning that someone recalling events when they were intoxicated are unreliable. This is because, excessive alcohol consumption restricts the brain's ability to transfer short-term memories to the hippocampus where long-term memory is stored (White, 2003); commonly referred to as 'alcoholic blackouts'. Additionally, half of the participants were in stable, long-term recovery (between five and 35 years) and recalling events and experiences can be challenging for some individuals as they age (Rhodes et al., 2019).

Ideally, to test for differences in levels of MPL in the very different contexts of active drinking and recovery, would mean measuring MPL, firstly, in early- and late-onset problem drinkers who were either actively drinking, or more likely in treatment and very early-recovery, against former early- and late-onset groups who were in stable recovery; this is something that should be a consideration for future research in this area. An even more ambitious design might consider following these populations (and levels of MPL) over the course of their recovery journeys. This would, however, require a completely different research design (i.e., a prospective design) which, potentially, presents far greater ethical challenges. However, a prospective design, would mean that the resulting data would be more authentic and reliable.

Like any group experiencing problems with addiction, problematic drinkers come from every socioeconomic group. However, the participants who volunteered to be interviewed were, predominantly, of a professional status. Of course, the similarity in the socioeconomic status of the sample may be coincidental. Although more likely, it can be explained by self-selection bias; individuals who volunteer to participate in research tend to share several characteristics: they are usually better educated, are from a higher SES, and are interested in

the topic of the research they are volunteering for (Nikolopoulou, 2022). Thus, it could be argued that any results, to some degree, may have been influenced by self-selection bias. However, the qualitative data generated from the participants' uniquely personal accounts, does not, and is not meant to generalise to the wider population of problematic drinkers per se.

Additionally, there was an oversight regarding the ethnic diversity of the thesis' sample population. This could have been addressed by simply including an ethnicity (race) option in the survey's demographic form (e.g., Black African, Black Caribbean, Asian, etc.); race is one of nine protected characteristics recognised by the Equality Act 2010 and is a valuable option to include in demographic forms and surveys. Typically, black and ethnic minorities (BME) are under-represented in drug and alcohol services in the UK (Bayley & Hurcombe, 2011). However, a review on the topic concluded there was "no consensus within the literature as to whether strong ethnic identity is more likely to act as a protective or restrictive factor" for people seeking help for problematic use of alcohol (Gleeson et al., 2019, p. 3), a phenomenon that is not limited to the UK. For instance, in the USA, disparities in mutual-aid group participation among ethnic minorities (Zemore et al., 2021) have become increasingly prevalent in recent years (Zemore et al., 2024), with BME people being less likely than the rest of the population to engage with alcohol services and mutual-aid organisations. Therefore, and line with Gleeson and colleagues' (2019) findings above, more research is required to better understand the disparities among BME populations and other minority groups seeking help from alcohol services and mutual-aid organisations for their problematic alcohol use.

7.8.2 Late-onset problem drinking and MPL — further investigations

Among the thesis' limitations highlighted in the sub-section above, two important areas of late-onset problem drinking warrant further investigation. Firstly, the thesis established the important role that MPL plays in recovery, and that there is a correlation between the length of time in recovery and the level of MPL. However, there is a need to better understand how MPL,

lacking, even absent, during active late-onset problem drinking, increases during recovery. Additionally, there is a need to better understand how MPL supports recovery. This would require an ambitious design, that would observe and follow late-onset problem drinkers at the beginning of their recovery journey, through to stable, long-term recovery. Secondly, another extremely important area that could have been more fully investigated in the main body of this thesis, is the association between retirement, identity, MPL and excessive alcohol consumption. Both, the literature review, and the main body of the thesis found that, after comorbid alcohol misuse and mental health issues, retirement and late-life stressors (e.g., age-related health issues and pain, loneliness), were the next most prevalent risk factors associated with late-onset problem drinking, and that late-onset problem drinkers use alcohol to fill the 'existential vacuum' and cope with the subsequent challenges to identity and self, that affects many people following retirement and other late-life stressors. Further investigations, therefore, are recommended in these two important areas and the following are suggestions for possible questions:

1) *Does the presence of meaning and purpose in life in late-onset problem drinkers change (over time), from the beginning of sobriety, through to stable, long-term recovery?*
2) *Does retirement affect the identities of late-onset problem drinkers?*
3) *Does retirement affect the levels of alcohol consumption among late-onset problem drinkers?*

7.9 REFLECTIONS OF A PhD JOURNEY

7.9.1 An Insider Perspective

Earlier in chapter three I disclosed my 'insider' status, i.e., I have lived experience of active problematic drinking and subsequent recovery (35-years). Being a researcher with an insider perspective can be extremely challenging; it can be beneficial, equally, it can be a hindrance.

On one hand, having the status of an 'expert by experience', means that one has personal experience of the object of investigation. On the other hand, however, over-familiarity with the object of investigation, can be challenging to one's objectivity. To manage this dichotomy, I have used the same technique, typically applied to the IPA method of qualitative research, Husserl's (1999) concept of bracketing (epoché), adapted by Smith et al. (2009) for IPA. In the context of the thesis' research as a whole, this has meant being constantly aware of my status as an insider, in order to mitigate against biases that may have influenced, and even contaminated the data and, thus, the supporting text. This method supported me to remain focussed and avoid making false assumptions and ill-informed judgments, that were based solely on my lived experience. Additionally, I have been extremely fortunate to have been in receipt of the knowledge, guidance and direction of my primary PhD supervisor, one of the leading researchers, globally, in the area of recovery, which has meant that every chapter has been thoroughly peer-reviewed. This is not to say that one completely discards the knowledge that accompanies one's lived experience journey. Nonetheless, bracketing has helped me to keep my insider status 'right sized'; I am, first and foremost, a researcher adhering to the scientific method.

However, regardless of applying Husserl's (1999) epoché technique and being acutely aware of my relationship with that which I am investigating, it would be extremely naïve of me to believe that my own lived experience of problem drinking and recovery has not directly influenced this thesis' research. I have, for example, helped many individuals during my time in recovery, which has given me direct experience of peer-based recovery support and how it works; naturally, I am passionate about the model because I know from direct experience how powerful and beneficial peer-based recovery support can be to the 'newcomer' in recovery and as such, I write about the construct from a favourable perspective. Additionally, and conversely, it is important for me to acknowledge how much my views and thoughts about

recovery have shifted, changed and developed over three decades. An example of this is my relationship with A.A. I have acquired knowledge, grown, developed and become responsible for my own recovery. Indeed, some time ago, I detached myself from that mutual-aid organisation, which I found to be a liberating experience; towards the end of this section, I discuss my relationship with A.A. in detail. Simply reflecting on that relationship, is, I think, a measure of how much my insider perspective has influenced my research.

This reflective section is not about telling my story per se, rather, it is about my PhD journey, in which hopefully, I have contributed and added knowledge to a much under-researched area of alcohol harm, i.e., late-onset problematic drinking. However, a short biography of my own recovery journey to date, will provide a useful contextual framework for the discussion. I am in my thirty-fourth year of recovery, although my preferred term nowadays (for myself anyway) is development, I have simply developed as a human being; to quote Jack, one of the late-onset participants in chapters four and five, "I just don't drink"; my decision is not about either semantics or stigma, it simply makes more sense to me. Indeed, regarding stigma, one of the first things that I learned when I started my PhD journey, was about the stigmatisation associated with problematic drinking and addiction. This was pointed out to me by my peer PhD students, many of whom work in settings with people recovering from addiction. For 30 years, as a member of A.A., I had mechanically and repeatedly used 'alcoholic' as a supplementary noun to my name when speaking at A.A. meetings, i.e., "My name is Kevin and I am an alcoholic." Why are people in recovery in A.A. constantly encouraged to reinforce an alcoholic identity? People are not alcoholics, they are human beings. I no longer attend A.A. meetings, which I will later expand on. Nonetheless, such rote-like behaviour, conditioned me into accepting the word *alcoholic* as normal, which of course it is not. So, to have the negative nature of stigmatising language pointed out to me, as well as being a moment of enlightenment, had a huge impression on me. So much so, that I made a decision

to apply a softer, and hopefully, non-stigmatising language throughout the thesis. Of course, there have been times, because of context, when the older vocabulary associated with addiction has been employed.

Mentioned earlier in chapter three, my own recovery (development) story began on the 14 August 1990, when I was admitted to Pinel House, an annex of Warlingham Park psychiatric hospital. Founded in 1952, by Max Glatt, a psychiatrist specialising in addiction, and funded by the NHS, Pinel House was the first detoxification/rehabilitation centre for problem drinkers (*alcoholics*) in the UK. In 1980 there were estimated to be 35 NHS rehabilitation units (Glatt, 1991), all based on the Pinel model; today, there are no such facilities in NHS settings. Interestingly, and noted earlier in the thesis, Glatt was one of the first researchers to investigate late-life problem drinking (Glatt et al., 1978; Rosin, & Glatt, 1971). Physically dependent on alcohol (addicted), I was medically detoxed at Pinel House. At some point, during my early days at Pinel House, I accepted my condition. Following that deep level of acceptance, the all-consuming psychological obsession with alcohol, more often referred to as a compulsion, left me; it has never returned. I view this process as an example of abstinence self-efficacy. I should add, however, that there were a few painful, false starts before reaching that point of acceptance. Additionally, and although I was not aware of it at the time, I was taking responsibility for my being. Responsibility, or 'responsibleness' (Frankl's preferred term) is one of logotherapy's major tenets; with hindsight, the following quote succinctly captures the empowering process of taking responsibility: "*What we have done, cannot be undone. This adds to man's responsibleness. For in the face of the transitoriness of his life, he is responsible for using the passing opportunities to actualise potentialities, to realise values, whether creative, experiential, or attitudinal. In other words, man is responsible for what to do, whom to love, and how to suffer*" (Frankl, 2014, p. 52).

During my time at Pinel House I was introduced to the A.A. paradigm, and after being discharged, I became a fervently active member; in 1990 there were no alternatives, certainly none that I was aware of. Over the years and decades, I had often reflected on and questioned the disease concept of problematic drinking/alcoholism, propagated by A.A., the efficacy of A.A.'s 12-step programme, A.A.'s religiosity and its insistence that sobriety/recovery is dependent on the belief in a 'Higher Power'; the A.A. paradigm effectively means that the individual is not responsible for their sobriety and recovery, arguably, their Higher Power assumes responsibility. Additionally, A.A.'s resistance to change was also a constant concern. Three years ago, during the COVID19 lockdown, and feeling like a round peg in a square hole, I openly declared at an online A.A. meeting, 'I can't do this anymore'. That was my last meeting. This disclosure is extremely important, as A.A. is mentioned often throughout the thesis. Reflecting on my decades-long involvement with A.A., has allowed me to bracket my personal relationship with A.A., in my effort to remain objective, arguably with varying degrees of success. I have been to thousands of A.A. meetings and have been involved in 'service' in A.A. at every level. As such, my thoughts and discourses around A.A. can rightly be interpreted as a 30-year-long ethnographic study, in which I have thoroughly explored the function of the mutual-aid model of recovery. My mini-critique of A.A., therefore, has been based on an existing body of academic evidence, and a 30-year-long ethnographic research project. Moreover, what I have learned while carrying out the research in this thesis has given me a fuller understanding and healthier perspective of the mutual-aid model. During data collection, for example, the number and eclectic mixture of mutual-aid groups I encountered was a wonderfully refreshing experience (e.g., Sober Punks, Women for Sobriety). This relatively recent proliferation of mutual-aid groups confirms something that I have been convinced about for a considerable time. That is (already noted earlier in the text), mutual-aid

groups (including A.A.) are effective because of a shared model of peer-based recovery support, which is so important to people in early recovery.

7.9.2 Finding MPL on the journey

This second sub-section, which presents my overall reflections, may read like a stream of consciousness and random thoughts. Although I have recorded my PhD journey and related experiences in diary format over the last three years, it was inappropriate to include here; not only because of its length (10,000 words), but also because of its style; it is a linear 'matter-of-fact' record, rather than a reflective journal, per se. It was, however, a useful point of reference, particularly during the analytical phases of the qualitative studies, when it was used to record my post-interview reflections. I have often said to people who have enquired about my undertaking a PhD, that the criterion for (hopefully) completing the project, required two things of me: a) application, and b) staying alive. I will briefly address the second point first, which is far more difficult to predict than the first point, indeed, impossible; although I can try to mitigate against my demise, the ultimate decision will not be mine. The first point, however, I have found relatively easy. Self-knowledge has shown me that, at times, my character can err on the side of obsessiveness. When I set out to achieve something, I tend to dedicate myself solely to that purpose. Of course, having a passion for the object of investigation, is also useful.

The last twelve years, for instance, has been a period of almost constant studying, in which I have achieved a BSc in psychology, a MSc in health psychology and this thesis, all of which is a testament to my single-mindedness. Framed within Frankl's theory of meaning, ironically, my journey has been my life's purpose for over the last decade and has ultimately generated meaning in my life and being. At the end of chapter six, I stated that '*purpose in life and meaning in life are inseparable constructs*' and that the relationship would be discussed further in this chapter. I think the previous sentence is a perfectly simple example of the relationship between these two psychological, and I would also confidently add, spiritual

constructs; spiritual in the sense of Frankl's and Maslow's meaning of spirituality, transcendence and self-actualisation (see for example, Papaleontiou-Louca et al., 2022). So, although the above example suggests that purpose in life begets meaning in life, which in this instance it surely does, the two constructs are fundamentally different, yet at the same time, inseparable. As an aside, there is a tenuous link between my academic journey and the two areas where I recommended further research would be useful. That is, when I was 60-years old, I was made redundant after, approximately, a 40-year career in advertising; I was a graphic designer/typographer. Financially, I probably could have retired. However, in line with the theoretical framework of this thesis, my life needs purpose. When I was growing up in the sixties, working class children were not encouraged to go to university and I had never considered an academic path. Therefore, I decided to undertake a degree in psychology. Alongside my academic journey, I worked in residential care, supporting young people and adults with learning difficulties and autism. I have turned the negative experience of redundancy into a positive experience and re-invented myself.

7.9.3 Why late-onset problem drinking?

Finally, it is important to explain the context in which the thesis was conceived and how the concept evolved. Theory has been thoroughly discussed and reported throughout the thesis, but how and why did I choose late-onset problem drinking? Because of my own development, I was/am interested in exploring how people of a similar age and also in long-term recovery experienced aging, and, importantly, how they cope with the physical and psychological events, changes and challenges that typically accompany the aging process. Initially, I had chosen spirituality and long-term recovery (published, McInerney, & Cross, 2021) and aging and long-term recovery (published, McInerney et al., 2021) as topics for two studies undertaken during my health psychology MSc. Coincidentally, at the time, I had also discovered and became interested in Frankl's logotherapy, and his *existential vacuum* concept, and decided

that it would be an appropriate theoretical framework for my thesis. Having decided to undertake a PhD, I put together a list of possible topics, including, 'Investigating the phenomenon of alcoholism developing in older adults'; note the use of 'alcoholism', I had yet to become aware of the stigma associated with the word, and using an alternative softer, more inclusive and less stigmatising language for the thesis. Nonetheless, the studies undertaken during my MSc meant that I was familiar with researching older problem drinkers in recovery, and also felt comfortable using Frankl's theory of meaning as a theoretical framework. It was while undertaking some initial reading on the general population of older problem drinkers, that I encountered the term 'late-onset' problem drinkers, which completed the thesis' subject matter and title: *Late-onset Alcohol Use Disorder/Problem Drinking — Psychosocial Characteristics and the Role of Meaning and Purpose in Life.* That was three years ago and the beginning of a journey that is nearing its destination.

7.10 CONCLUSIONS

Comprised of three studies and a systematic literature review, the thesis investigated and reported on an under-researched population of problem drinkers, categorised as *late-onset* and estimated to constitute one-third of older, problem drinkers. Using a mixed-method, comparative methodology, the three studies posed a number of research questions and hypotheses, to investigate and compare late-onset problem drinkers and their early-onset counterparts and, importantly, to better understand why the late-onset cohort's alcohol consumption became problematic later in their lives. Although the literature review posed different research questions than the thesis' three studies, in essence, all four elements of the thesis investigated two psychological constructs: psychosocial characteristics and the role of MPL. Additionally, the recovery pathways of both groups were investigated and reported. Overall, the findings showed that the research questions have been extensively addressed.

In the context of psychosocial characteristics, as hypothesised, there were recognisable differences between both cohorts when they were actively drinking; explanations why drinking can become problematic later in life were reported, supporting the notion of a distinct population of late-onset problematic drinkers. However, recovery does not discriminate, and the psychosocial differences between the groups dissipated in the common experience of sobriety and recovery. That said, recovery is a uniquely personal journey of psychological and spiritual development. In contrast, MPL did not differentiate between the groups, in either the active drinking phase or in recovery. Not surprisingly, as hypothesised, MPL did not feature as prominently in either group when they were drinking as it did, later in recovery. Indeed, a noticeable feature of both groups when they were actively drinking was a lack of MPL. In contrast, MPL emerged as an essential component of RC, necessary to promote and maintain recovery, highlighted in the significant, positive correlation between the degree of MPL and length of time in recovery. Further, from social and psychological perspectives, respectively, peer-based recovery support, abstinence self-efficacy and MPL, emerged as a triad of essential components in recovery.

Additionally, other important considerations that emerged during the thesis' investigations were noted. The landscape of mutual-aid pathways, for instance, has changed considerably. The thesis reported that the late-onset participants in the three studies were significantly more likely to engage with contemporary mutual-aid models, rather than the traditional A.A. model, an important finding that both, treatment and healthcare professionals should consider, when referring their clients/patients to post-treatment mutual-aid pathways. As suggested above, there is much room for further research in the area of late-onset problem drinking. However, this thesis and the effective dissemination of its contents, can make a considerable contribution in informing treatment and healthcare professionals about the needs

of late-onset drinkers and, importantly, help to create a greater awareness of this 'invisible' cohort of problematic drinkers.

Chapter endnotes

1. There are instances during the thesis where, unavoidably, there are occasional references to stigmatising language, i.e., 'alcoholic', 'alcoholism'. This was because of: a) historical context and b) direct quotations.
2. The *Washingtonians Total Abstinence Society* was a temperance society but not part of the temperance movement per se. A non-religious organisation, the society was founded by six problem drinkers, in Baltimore, USA, in 1840, almost 100 years before A.A. emerged. The *Washingtonians* secular model of recovery was, in essence, peer-based recovery support. They became very successful in a short space of time and at the height of their popularity, they were estimated to number 600,000. However, many of the powerful and eloquent speakers within their ranks were recruited by other high profile social movements, to speak on their behalf (e.g., abolitionists, the generic temperance movement); this proved to be a diversion from their primary purpose and heralded their downfall. They became so completely extinct, that A.A. founder, Bill Wilson, had never heard of them when he founded A.A. in 1935. However, by the time he came to write A.A.'s 12 Traditions (1953), he had familiarised himself with the *Washingtonians'* history. Indeed, the experiences surrounding the *Washingtonians'* demise, appear to have been the inspiration for A.A.'s tenth Tradition: *Alcoholics Anonymous has no opinion on outside issues; hence the A.A. name ought never be drawn into public controversy*.
3. A.A.'s twelfth step is divided into two halves 1) *Having had a spiritual awakening as the result of these Steps, we tried to carry this message to alcoholics,* 2) *and to practice these principles in all our affairs.* The first half can be viewed as a model for peer-based recovery support. However, the footnote (above) indicates that the model was not conceived by A.A. Indeed, the reciprocal, altruistic behaviour involved in peer-based recovery support (or more broadly speaking, human empathy) is thought to be an evolutionary adaption, designed to be equally beneficial to both, the 'giver' and the 'recipient'. Theoretically, as discussed above, peer-based recovery support mediates MPL. It is worth highlighting step twelve's overarching assumption that people will undergo, *a spiritual awakening as the result of these Steps*. It is also worth reflecting on Bill Wilson's, questionable, 'spiritual experience' on which this step and much of A.A. philosophy and the A.A. programme is based. Wilson's epiphany, however, may have been hallucinatory in nature, induced by *Atropa belladonna* (deadly nightshade), known to have hallucinogenic properties (Bevacqua & Hoffman, 2010; Markel, 2010); the so called, *belladonna regime*, was a part of the standard treatment in the Towns Hospital, New York, where Wilson underwent detoxification in 1934. Wilson's alleged spiritual experience, also reflects (almost exactly) a "blinding light" experience that his grandfather had at the end of his own problem drinking; his grandfather had a big influence on Wilson, whose own father had deserted him when he was eleven years old (Dodes & Dodes, 2015, p. 14). Alternatively, he may simply have been experiencing alcoholic delirium tremens (Markel, 2010). Regardless of the source, Wilson postulated that a '*spiritual awakening*' was essential to recovery, and thus, the concept became embedded in the A.A. paradigm.
4. For a comprehensive history of the recovery movement in the UK, also refer to: Humphreys and Lembke (2014); Roth and Best (2013).

5. A.A.'s claim that it doesn't work for everyone, like all of A.A.'s claims, is not based on empirical evidence. Oddly enough, the statement, which is arguably, judgmental, and lacking in either empathy or compassion, is read out, approvingly, at the beginning of most A.A. meetings: *"Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault, they seem to have been born that way"* (A.A. 2001, p. 64). In essence, the statement posits the notion that, 'if A.A. doesn't work for you, it's not the A.A. programme that is at fault, it's you'.
6. The A.A. programme is presented in the first 164 pages of its primary text, the 'Big Book'. The male pronoun is used exclusively throughout. Understandably, it is the language of the time when it was written, 1939. Arguably, the book needs to be comprehensively edited, using a gender-inclusive language that reflects its membership.
7. Marty Mann founded the National Committee for Education on Alcoholism (NCEA), which later became the influential National Council on Alcoholism and Drug Dependence (NCADD). Mann is considered to be the first women in A.A. with long-term recovery; she was a close friend of Bill Wilson and also Dr. E. Jellinek, who proposed *the disease concept of alcoholism* (Jellinek, 1960). Mann partially funded an earlier Jellinek study on alcoholism (Jellinek, 1946), whose sample was made up exclusively of A.A. members. Mann was a passionate advocate of both A.A. and the disease concept of alcoholism and was instrumental in getting 12-step programmes embedded in treatment and rehabilitation centres in the USA (the *Minnesota Model*). Although Mann died in 1980, A.A. is still influential in the NCADD; see, for example, *Alcoholics Anonymous and The Atlantic: A call for better science* (NCADD, 2016).
8. Indeed, greater access to RC leads to improved outcomes for all problem drinkers.

References

Adams, S. L. (1990). *Late onset alcoholism in a midwestern setting: a matter of complexity* (Doctoral dissertation, The University of Nebraska-Lincoln).

Adams, S. L., & Waskel, S. A. (1991a). Comparisons of purpose in life scores between alcoholics with early and later onset. *Psychological reports*, *69*(3), 837-838. https://doi.org/10.2466/pr0.1991.69.3.837

Adams, S. L., & Waskel, S. A. (1991b). Late onset of alcoholism among older midwestern men in treatment. *Psychological reports*, *68*(2), 432-434. https://doi.org/10.2466/pr0.1991.68.2.432

Adams, S. L., & Waskel, S. A. (1993). Late onset alcoholism: Stress or structure. *The Journal of psychology*, *127*(3), 329-334. https://doi.org/10.1080/00223980.1993.9915567

Agabio, R., Trogu, E., Pani, P. P., & Pani, P. P. (2018). Antidepressants for the treatment of people with co-occurring depression and alcohol dependence. *Cochrane Database of Systematic Reviews*, *2018*(4), CD008581–. https://doi.org/10.1002/14651858.CD008581.pub2

Age Concern (2007), Improving Services and Support to Older People with Mental Health Problems-Second Report from the UK Enquiry into Mental Health and Wellbeing in Later Life, Age Concern, London. http://www.mentalhealthpromotion.net/resources/improving-services-and-support-for-older-people-with-mental-health-problems.pdf

Age UK. (2019, July). *Briefing: Health and Care of Older People in England 2019*. https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/age_uk_briefing_state_of_health_and_care_of_older_people_july2019.pdf

Alcoholics Anonymous Great Britain. (2022, July). *Interesting Statistics*. https://www.alcoholics-anonymous.org.uk/Professionals/Interesting-Statistics

Alcoholics Anonymous World Services. (1985). *Alcoholics Anonymous comes of age — A brief history of A.A.* Alcoholics Anonymous World Services Inc.

Alcoholics Anonymous World Services. (2001). *Alcoholics Anonymous: The story of how thousands of men and women have recovered from alcoholism* (4th ed.). Alcoholics Anonymous World Services Inc.

Alcoholics Anonymous World Services. (1953). *Twelve steps and twelve traditions*. Alcoholics Anonymous World Services Inc.

Alcohol Policy UK. (2020, June 11). *Alcohol and older adults: time for change?* https://www.alcoholpolicy.net/2019/06/alcohol-and-older-adults-time-for-change.html

Alimujiang, A., Wiensch, A., Boss, J., Fleischer, N. L., Mondul, A. M., McLean, K., ... & Pearce, C. L. (2019). Association between life purpose and mortality among US adults older than 50 years. *JAMA network open*, *2*(5), e194270-e194270. https://doi.org/10.1001/jamanetworkopen.2019.4270

Allan, C. A., & Cooke, D. J. (1985). Stressful life events and alcohol misuse in women: a critical review. *Journal of Studies on Alcohol*, *46*(2), 147-152. https://doi.org/10.15288/jsa.1985.46.147

Al-Otaiba, Z., Epstein, E. E., McCrady, B., & Cook, S. (2012). Age-based differences in treatment outcome among alcohol-dependent women. *Psychology of Addictive Behaviors*, *26*(3), 423. https://doi.org/10.1037/a0027383

American Psychiatric Association. (1980). *Diagnostic and Statistical Manual of Mental Disorders.* (3rd ed.). Arlington, VA: Author.

American Psychiatric Association. (2013). Substance-Related and Addictive Disorders. In *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: Author.

American Psychological Association. (2023, November 15). *APA Dictionary of Psychology*. https://dictionary.apa.org/socioeconomic-status

Andersen, K., Bogenschutz, M. P., Bühringer, G., Behrendt, S., Bilberg, R., Braun, B., ... & Nielsen, A. S. (2015). Outpatient treatment of alcohol use disorders among subjects 60+ years: Design of a randomized clinical trial conducted in three countries (Elderly Study). *BMC psychiatry*, *15*(1), 1-11. https://doi.org/10.1186/s12888-015-0672-x

Andreas, D., Ja, D. Y., & Wilson, S. (2010). Peers reach out supporting peers to embrace recovery (PROSPER): a center for substance abuse treatment recovery community services program. *Alcoholism Treatment Quarterly*, *28*(3), 326-338. https://doi.org/10.1080/07347324.2010.488538

Antonovsky, A. (1993). The structure and properties of the sense of coherence scale. *Social science & medicine*, *36*(6), 725-733. https://doi.org/10.1016/0277-9536(93)90033-Z

Arthur, T. S. (1865). *Six nights with the Washingtonians*. Peterson.

Ashford, R. D., Brown, A. M., Dorney, G., McConnell, N., Kunzelman, J., McDaniel, J., & Curtis, B. (2019). Reducing harm and promoting recovery through community-based mutual aid: Characterizing those who engage in a hybrid peer recovery community organization. *Addictive Behaviors*, *98*, 106037–106037. https://doi.org/10.1016/j.addbeh.2019.106037

Ashford, R. D., Brown, A. M., McDaniel, J., & Curtis, B. (2019). Biased labels: An experimental study of language and stigma among individuals in recovery and health professionals. *Substance use & misuse*, *54*(8), 1376-1384. https://doi.org/10.1080/10826084.2019.1581221

Atkinson, R. M. (1990). Aging and alcohol use disorders: Diagnostic issues in the elderly. *International Psychogeriatrics*, *2*(1), 55-72. https://doi.org:10.1017/S1041610290000308

Atkinson, R. M., Tolson, R. L., & Turner, J. A. (1990). Late versus early onset problem drinking in older men. *Alcoholism: Clinical and Experimental Research*, *14*(4), 574-579. https://doi.org/10.1111/j.1530-0277.1990.tb01203.x

Atkinson, R. M., Turner, J. A., Kofoed, L. L., & Tolson, R. L. (1985). Early versus late onset alcoholism in older persons: Preliminary findings. *Alcoholism: Clinical and Experimental Research*, *9*(6), 513-515. https://doi.org/10.1111/j.1530-0277.1985.tb05594.x

Ashford, R. D., Brown, A. M., McDaniel, J., & Curtis, B. (2019). Biased labels: An experimental study of language and stigma among individuals in recovery and health professionals. *Substance use & misuse*, *54*(8), 1376-1384. https://doi.org/10.1080/10826084.2019.1581221

Audi, R. (1999). The Cambridge dictionary of philosophy.

Auhagen, A. E. (2000). On the psychology of meaning of life. *Swiss Journal of Psychology/Schweizerische Zeitschrift für Psychologie/Revue Suisse de Psychologie*, *59*(1), 34. https://doi.org/10.1024/1421-0185.59.1.34

Ayres, R. M., Eveson, L., Ingram, J., & Telfer, M. (2012). Treatment experience and needs of older drug users in Bristol, UK. *Journal of Substance Use*, *17*(1), 19-31. https://doi.org/10.3109/14659891.2010.513756

Azarian, R. (2011). Potentials and limitations of comparative method in social science. *International Journal of Humanities and Social Science*, *1*(4), 113-125.

Babatunde, O. T., Outlaw, K. R., Forbes, B., & Gay, T. (2014). Revisiting baby boomers and alcohol use: Emerging treatment trends. *Journal of Human Behavior in the Social Environment*, *24*(5), 597-611. https://doi.org/10.1080/10911359.2014.914830

Bakhshi, S., & While, A. E. (2014). Older people and alcohol use. *British Journal of Community Nursing*, *19*(8), 370–374. https://doi.org/10.12968/bjcn.2014.19.8.370

Bamberger, P. A. (2015). Winding down and boozing up: The complex link between retirement and alcohol misuse. *Work, Aging and Retirement*, *1*(1), 92-111. https://doi.org/10.1093/workar/wau001

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American psychologist*, *37*(2), 122-147. https://doi.org/10.1037/0003-066X.37.2.122

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Bandura, A., & Schunk, D. H. (1981). Cultivating competence, self-efficacy, and intrinsic interest through proximal self-motivation. *Journal of personality and social psychology*, *41*(3), 586. https://doi.org/10.1037/0022-3514.41.3.586

Bandura, A., & Walters, R. H. (1977). *Social learning theory* (Vol. 1). Prentice Hall: Englewood cliffs.

Bareham, B. K., Kaner, E., Spencer, L. P., & Hanratty, B. (2019). Drinking in later life: a systematic review and thematic synthesis of qualitative studies exploring older people's perceptions and experiences. *Age and ageing*, *48*(1), 134-146. https://doi.org/10.1093/ageing/afy069

Bareham, B. K., Stewart, J., Kaner, E., & Hanratty, B. (2021). Factors affecting primary care practitioners' alcohol-related discussions with older adults: a qualitative study. *British journal of general practice*, *71*(711), e762-e771. https://doi.org/10.3399/BJGP.2020.1118

Barker, S. L., Maguire, N., Bishop, F. L., & Stopa, L. (2018). Peer support critical elements and experiences in supporting the homeless: A qualitative study. *Journal of Community & Applied Social Psychology*, *28*(4), 213–229. https://doi.org/10.1002/casp.2353

Barker, S. L., & Maguire, N. (2017). Experts by Experience: Peer Support and its Use with the Homeless. *Community Mental Health Journal*, *53*(5), 598–612. https://doi.org/10.1007/s10597-017-0102-2

Battista, J., & Almond, R. (1973). The development of meaning in life. *Psychiatry*, *36*(4), 409-427. https://doi.org/10.1080/00332747.1973.11023774

Bayley, M., & Hurcombe, R. (2011). Drinking patterns and alcohol service provision for different ethnic groups in the UK: a review of the literature. *Ethnicity and inequalities in health and social care*, *3*(4), 6-17. https://doi.org/10.5042/eihsc.2011.0073

Beales, A., & Wilson, J. (2015). Peer support – the what, why, who, how and now. *The Journal of Mental Health Training, Education, and Practice*, *10*(5), 314–324. https://doi.org/10.1108/JMHTEP-03-2015-0013

Bell, S., & Britton, A. (2014). An exploration of the dynamic longitudinal relationship between mental health and alcohol consumption: a prospective cohort study. *BMC medicine*, *12*(1), 1-13. https://doi.org/10.1186/1741-7015-12-91

Bergin, M. (2011). NVivo 8 and consistency in data analysis: Reflecting on the use of a qualitative data analysis program. *Nurse researcher*, *18*(3). https://doi.org/10.7748/nr2011.04.18.3.6.c8457

Berglund, K. J., Rauwolf, K. K., Berggren, U., Balldin, J., & Fahlke, C. (2019). Outcome in Relation to Drinking Goals in Alcohol-Dependent Individuals: A Follow-up Study 2.5 and 5 Years After Treatment Entry. *Alcohol and Alcoholism (Oxford)*, *54*(4), 439–445. https://doi.org/10.1093/alcalc/agz042

Berking, M., Margraf, M., Ebert, D., Wupperman, P., Hofmann, S. G., & Junghanns, K. (2011). Deficits in emotion-regulation skills predict alcohol use during and after cognitive–behavioral therapy for alcohol dependence. *Journal of consulting and clinical psychology*, *79*(3), 307. https://doi.org/10.1037/a0023421

Best, D. (2019). *Pathways to recovery and desistance*. Policy Press

Best, D., Albertson, K., Irving, J., Lightowlers, C., Mama-Rudd, A., & Chaggar, A. (2015). The UK life in recovery survey 2015: The first national UK survey of addiction recovery experiences.

Best, D., & Aston, E. (2015). Long term recovery from addiction: criminal justice involvement and positive criminology?. https://doi.org/0000-0002-6792-916X

Best, D., Beckwith, M., Haslam, C., Alexander Haslam, S., Jetten, J., Mawson, E., & Lubman, D. I. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition:

The social identity model of recovery (SIMOR). *Addiction Research & Theory*, *24*(2), 111-123. https://doi.org/10.3109/16066359.2015.1075980

Best, D., Colman, C., Vanderplasschen, W., Vander Laenen, F., Irving, J., Edwards, M., ... & Martinelli, T. (2019). How do mechanisms for behaviour change in addiction recovery apply to desistance from offending?: Learning lessons from the REC-PATH programme of work. In D. Best, & C. Colman (Eds.), *Strengths-based approaches to crime and substance use* (pp. 86-102). Routledge.

Best, D., Critchlow, T., Higham, D., Higham, K., Thompson, R., Shields, D., & Barton, P. (2022). Delivering Peer-Based Support in Prisons During the COVID Pandemic and Lockdown: Innovative Activities Delivered by People Who Care. International Journal of Offender Therapy and Comparative Criminology, 306624–306624X221110809. https://doi.org/10.1177/0306624X221110809

Best, D., Gow J., Knox, T., Taylor, A., Groshkova, T., & White, W. (2012). Mapping the recovery stories of drinkers and drug users in Glasgow: Quality of life and its associations with measures of recovery capital. *Drug and Alcohol Review*, *31*(3), 334–341. https://doi.org/10.1111/j.1465-3362.2011.00321.x

Best, D., Gow, J., Taylor, A., Knox, A., & White, W. (2011a). Recovery from heroin or alcohol dependence: A qualitative account of the recovery experience in Glasgow. *Journal of Drug Issues*, *41*(3), 359-377. https://doi.org/10.1177/002204261104100303

Best, D., Groshkova, T., Sadler, J., Day, E., & White, W. L. (2011b). What is recovery? Functioning and recovery stories of self-identified people in recovery in a services user group and their peer networks in Birmingham England. *Alcoholism Treatment Quarterly*, *29*(3), 293-313.https://doi.org/10.1080/07347324.2011.586270

Best, D., & Hennessy, E. A. (2022). The science of recovery capital: where do we go from here?. *Addiction*, *117*(4), 1139-1145. https://doi.org/10.1111/add.15732

Best, D., Higham, D., Pickersgill, G., Higham, K., Hancock, R., & Critchlow, T. (2021a). Building recovery capital through community engagement: A hub and spoke model for peer-based recovery support services in England. *Alcoholism Treatment Quarterly*, *39*(1), 3-15. https://doi.org/10.1080/07347324.2020.1787119

Best, D., Irving, J., Collinson, B., Andersson, C., & Edwards, M. (2017). Recovery networks and community connections: Identifying connection needs and community linkage opportunities in early recovery populations. *Alcoholism Treatment Quarterly*, *35*(1), 2-15. https://doi.org/10.1080/07347324.2016.1256718

Best, D., McKitterick, T., Beswick, T., & Savic, M. (2015). Recovery capital and social networks among people in treatment and among those in recovery in York, England. *Alcoholism Treatment Quarterly*, *33*(3), 270-282.https://doi.org/10.1080/07347324.2015.1050931

Best, D., Sondhi, A., Brown, L., Nisic, M., Nagelhout, G. E., Martinelli, T., ... & Vanderplasschen, W. (2021b). The Strengths and Barriers Recovery Scale (SABRS): Relationships matter in

building strengths and overcoming barriers. *Frontiers in Psychology*, *12*, 663447. https://doi.org/10.3389/fpsyg.2021.663447

Best, D., Vanderplasschen, W., De Maeyer, J., Van de Mheen, D., Bellaert, L., Nagelhout, G., … Patton, D. (2021c). *REC-PATH: Recovery pathways and societal responses in the UK, Netherlands and Belgium : final report*. Brussels: Belgian Science Policy Office (BELSPO).

Best, D., Vanderplasschen, W., Van de Mheen, D., De Maeyer, J., Colman, C., Vander Laenen, F., ... & Nagelhout, G. E. (2018). REC-PATH (recovery pathways): overview of a four-country study of pathways to recovery from problematic drug use. *Alcoholism Treatment Quarterly*, *36*(4), 517-529. https://doi.org/10.1080/07347324.2018.1488550

Bevacqua, T., & Hoffman, E. (2010). William James's "sick-minded soul" and the AA recovery paradigm: Time for a reappraisal. *Journal of Humanistic Psychology*, *50*(4), 440–458. doi:10.1177/0022167810373041

Bilevicius, E., Kempe, T., Pankratz, L., Wardell, J. D., Johnson, E. A., & Keough, M. T. (2021). Shame's Associations with Depression and Problem Drinking: An Ecological Momentary Study. *Substance Use & Misuse*, *56*(11), 1715–1725. https://doi.org/10.1080/10826084.2021.1949616

Billig, M., & Tajfel, H. (1973). Social categorization and similarity in intergroup behaviour. *European journal of social psychology*, *3*(1), 27-52. https://doi.org/10.1002/ejsp.2420010202

Bischof, G., Rumpf, H.-J., Meyer, C., Hapke, U., & John, U. (2005). Gender differences in temptation to drink, self-efficacy to abstain and coping behavior in treated alcohol-dependent individuals: Controlling for severity of dependence. *Addiction Research & Theory*, *13*(2), 129–136. https://doi.org/10.1080/16066350412331335305

Blow, F. C. (2000). Treatment of older women with alcohol problems: Meeting the challenge for a special population. *Alcoholism: Clinical and Experimental Research*, *24*(8), 1257-1266. https://doi.org/10.1111/j.1530-0277.2000.tb02092.x

Blow, F. C., & Barry, K. L. (2000). Older patients with at-risk and problem drinking patterns: New developments in brief interventions. *Journal of Geriatric Psychiatry and Neurology*, *13*(3), 115-123. https://doi.org/10.1177/089198870001300304

Blow, F. C., & Barry, K. L. (2002). Use and misuse of alcohol among older women. *Alcohol Research & Health*, *26*(4), 308.

Boeri, M., Gardner, M., Gerken, E., Ross, M., & Wheeler, J. (2016). "I don't know what fun is": examining the intersection of social capital, social networks, and social recovery. *Drugs and alcohol today*, *16*(1), 95-105. https://doi.org/10.1108/DAT-08-2015-0046

Boisvert, R. A., Martin, L. M., Grosek, M., & Clarie, A. J. (2008). Effectiveness of a peer-support community in addiction recovery: participation as intervention. *Occupational therapy international*, *15*(4), 205-220. https://doi.org/10.1002/oti.257

Bond, L. M., & Csordas, T. J. (2014). The paradox of powerlessness. *Alcoholism Treatment Quarterly*, *32*(2-3), 141-156. https://doi.org/10.1080/07347324.2014.907050

Bong, S. A. (2002, May). Debunking myths in qualitative data analysis. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *3*(2). https://doi.org/10.17169/fqs-3.2.849

Book, S. W., Thomas, S. E., Dempsey, J. P., Randall, P. K., & Randall, C. L. (2009). Social anxiety impacts willingness to participate in addiction treatment. *Addictive Behaviors*, *34*(5), 474-476. https://doi.org/10.1016/j.addbeh.2008.12.011

Bordia, P., Read, S., & Bordia, S. (2020). Retiring: Role identity processes in retirement transition. *Journal of Organizational Behavior*, *41*(5), 445-460. https://doi.org/10.1002/job.2438

Borrero, L., & Kruger, T. M. (2015). The nature and meaning of identity in retired professional women. *Journal of women & aging*, *27*(4), 309-329. https://doi.org/10.1080/08952841.2014.950141

Bougea, A., Despoti, A., & Vasilopoulos, E. (2019). Empty-nest-related psychosocial stress: Conceptual issues, future directions in economic crisis. *Psychiatriki*, *30*(4), 329-338. https://doi.org/10.22365/jpsych.2019.304.329

Boulze-Launay, I., & Rigaud, A. (2020). Alcohol and loneliness: In my solitude. *International Forum of Psychoanalysis*, *29*(2), 65–73. https://doi.org/10.1080/0803706X.2019.1693060

Bourdieu, P. (1986) The Forms of Capital, in J. Richardson (Ed.), *Handbook of Theory and Research for the Sociology of Education*, New York: Greenwood, pp. 241-258.

Bradizza, C. M., Brown, W. C., Ruszczyk, M. U., Dermen, K. H., Lucke, J. F., & Stasiewicz, P. R. (2018). Difficulties in emotion regulation in treatment-seeking alcoholics with and without co-occurring mood and anxiety disorders. *Addictive behaviors*, *80*, 6-13. https://doi.org/10.1016/j.addbeh.2017.12.033

Bradshaw, S., Shumway, S. T., Wang, E. W., Harris, K. S., Smith, D. B., & Austin-Robillard, H. (2015). Hope, readiness, and coping in family recovery from addiction. *Journal of Groups in Addiction & Recovery*, *10*(4), 313-336. https://doi.org/10.1080/1556035X.2015.1099125

Brassai, L., Piko, B. F., & Steger, M. F. (2011). Meaning in life: Is it a protective factor for adolescents' psychological health?. *International journal of behavioral medicine*, *18*, 44-51. https://doi.org/10.1007/s12529-010-9089-6

Brauer, S. (2018). The Surprising Predictable Decline of Religion in the United States. *Journal for the Scientific Study of Religion*, *57*(4), 654–675. https://doi.org/10.1111/jssr.12551

Brault, N., & Saxena, M. (2021). For a critical appraisal of artificial intelligence in healthcare: The problem of bias in mHealth. *Journal of Evaluation in Clinical Practice*, *27*(3), 513-519. https://doi.org/10.1111/jep.13528

Brennan, P. L., & Moos, R. H. (1991). Functioning, life context, and help-seeking among late-onset problem drinkers: comparisons with nonproblem and early-onset problem drinkers. *British Journal of Addiction*, *86*(9), 1139-1150. https://doi.org/10.1111/j.1360-0443.1991.tb01882.x

Brennan, P. L., & Moos, R. H. (1990). Life stressors, social resources, and late-life problem drinking. *Psychology and aging*, *5*(4), 491. http://doi.org/10.1037/0882-7974.5.4.491

Brennan, P. L., Moos, R. H., & Kim, J. Y. (1993). Gender differences in the individual characteristics and life contexts of late-middle-aged and older problem drinkers. *Addiction*, *88*(6), 781-790. https://doi.org/10.1111/j.1360-0443.1993.tb02092.x

Brennan, P. L., Schutte, K. K., & Moos, R. H. (2010). Retired status and older adults' 10-year drinking trajectories. *Journal of Studies on Alcohol and Drugs*, *71*(2), 165-168. https://doi.org/10.15288/jsad.2010.71.165

Brennan, P. L., SooHoo, S., Lemke, S., & Schutte, K. K. (2016). Alcohol use predicts 10-year depressive symptom trajectories in the health and retirement study. *Journal of aging and health*, *28*(5), 911-932. https://doi.org/10.1177/0898264315615837

Britt, K. C., & Acton, G. (2022). Exploring the meaning of spirituality and spiritual care with help from Viktor Frankl. *Journal of Holistic Nursing*, *40*(1), 46-55. https://doi.org/10.1177/08980101211026776

Brown, P. A., Harniss, M. K., Schomer, K. G., Feinberg, M., Cullen, N. K., & Johnson, K. L. (2012). Conducting systematic evidence reviews: core concepts and lessons learned. *Archives of physical medicine and rehabilitation*, *93*(8), S177-S184. https://doi.org/10.1016/j.apmr.2011.11.038

Bruce, M. L. (2002). Psychosocial risk factors for depressive disorders in late life. *Biological psychiatry*, *52*(3), 175-184. https://doi.org/10.1016/S0006-3223(02)01410-5

Bruner, T. (2012). Frankl's metapsychology revisited: Is there a Franklian epistemology. *International Journal of Existential Psychology & Psychotherapy*, *4*(1), 45-59.

Buckingham, S., Frings, D., & Albery, I.P. (2013). Group membership and social identity in addiction recovery. *Psychology of Addictive Behaviors*, *27*(4), 1132-1140. https://doi/ 10.1037/a0032480.

Buckner, J. D., Heimberg, R. G., Ecker, A. H., & Vinci, C. (2013). A biopsychosocial model of social anxiety and substance use. *Depression and anxiety*, *30*(3), 276-284. https://doi.org/10.1002/da.22032

Buckner, J. D., Timpano, K. R., Zvolensky, M. J., Sachs-Ericsson, N., & Schmidt, N. B. (2008). Implications of comorbid alcohol dependence among individuals with social anxiety disorder. *Depression and Anxiety*, *25*(12), 1028-1037. https://doi.org/10.1002/da.20442

Bupić, J., & Bogović Dijaković, A. (2019). Meaning in Life and Personality Traits in Adult Alcoholics. *Archives of Psychiatry Research: An International Journal of Psychiatry and Related Sciences*, *55*(1), 39-48. https://doi.org/10.20471/may.2019.55.01.03

Byrne, G. J., Raphael, B., & Arnold, E. (1999). Alcohol consumption and psychological distress in recently widowed older men. *Australian & New Zealand Journal of Psychiatry*, *33*(5), 740-747. https://doi.org/10.1080/j.1440-1614.1999.00614.x

Canham, S. L., Mauro, P. M., Kaufmann, C. N., & Sixsmith, A. (2016). Association of Alcohol Use and Loneliness Frequency Among Middle-Aged and Older Adult Drinkers. *Journal of Aging and Health*, *28*(2), 267–284. https://doi.org/10.1177/0898264315589579

Cano, I., Best, D., Edwards, M., & Lehman, J. (2017). Recovery capital pathways: Modelling the components of recovery wellbeing. *Drug and alcohol dependence*, *181*, 11-19. https://doi.org/10.1016/j.drugalcdep.2017.09.002

Cargiulo, T. (2007). Understanding the health impact of alcohol dependence. *American journal of health-system pharmacy*, *64*(5_Supplement_3), S5-S11. https://doi.org/10.2146/ajhp060647

Carroll, S. (1993). Spirituality and purpose in life in alcoholism recovery. *Journal of studies on alcohol*, *54*(3), 297-301. https://doi.org/10.15288/jsa.1993.54.297

Cederbaum, A. I. (2012). Alcohol metabolism. *Clinics in liver disease*, *16*(4), 667-685. https://doi.org/10.1016/j.cld.2012.08.002

Centre for Ageing Better. (2020, November 20). *Alcohol and ageing well in a time of lockdown*. https://www.ageing-better.org.uk/blogs/alcohol-and-ageing-well-time-lockdown

Chapman, R. J. (1996). Spirituality in the treatment of alcoholism: A worldview approach. *Counseling and Values*, *41*(1), 39-50. https://doi.org/10.1002/j.2161-007X.1996.tb00861.x

Chen, G. (2006a). Social support, spiritual program, and addiction recovery. *International Journal of Offender Therapy and Comparative Criminology*, *50*(3), 306-323. https://doi.org/10.1177/0306624X05279038

Chen, G. (2006b). Natural Recovery from Drug and Alcohol Addiction Among Israeli Prisoners. *Journal of Offender Rehabilitation*, *43*(3), 1–17. https://doi.org/10.1300/J076v43n03_01

Child Mind Institute. (2023, February 23). *What is Social Anxiety? When fear of how you appear gets in the way of functioning*. https://childmind.org/article/what-is-social-anxiety/

Chinnusamy, M., Eugin, P. R., & Janakiraman, S. (2021). A study on the effect of alcoholism on the family members of alcoholic patients. *Journal of Health and Allied Sciences NU*, *11*(02), 066-072.https://doi.org/10.1055/s-0040-1722426

Chiu, M. Y., Ho, W. W., Lo, W. T., & Yiu, M. G. (2010). Operationalization of the SAMHSA model of recovery: A quality of life perspective. *Quality of Life Research*, *19*, 1-13. https://doi.org/10.1007/s11136-009-9555-2

Choi, B. C. Pak. AWP (2005). A catalog of biases in questionnaires. *Preventing Chronic Disease*, *2*(1), A13.

Christensen, A. S., & Elmeland, K. (2015). Former heavy drinkers' multiple narratives of recovery. *Nordic Studies on Alcohol and Drugs*, *32*(3), 245-257. https://doi.org/10.1515/nsad.-2015-0024

Christie, M. M., Bamber, D., Powell, C., Arrindell, T., & Pant, A. (2013). Older adult problem drinkers: Who presents for alcohol treatment?. *Aging & mental health*, *17*(1), 24-32. https://doi.org/10.1080/13607863.2012.696577

Cloud, W., & Granfield, R. (1994). Natural recovery from addiction treatment implications. *Addictions Nursing*, *6*(4), 112-116. https://doi.org/10.3109/10884609409021736

Cloud, W., & Granfield, R. (2001). Natural recovery from substance dependency: Lessons for treatment providers. *Journal of Social Work Practice in the Addictions*, *1*(1), 83-104. https://doi.org/10.1300/J160v01n01_07

Cohen, R., Bavishi, C., & Rozanski, A. (2016). Purpose in life and its relationship to all-cause mortality and cardiovascular events: A meta-analysis. *Psychosomatic medicine*, *78*(2), 122-133. https:// doi.org/10.1097/PSY.0000000000000274

Collins, S. E., Jones, C. B., Hoffmann, G., Nelson, L. A., Hawes, S. M., Grazioli, V. S., ... & Clifasefi, S. L. (2016). In their own words: content analysis of pathways to recovery among individuals with the lived experience of homelessness and alcohol use disorders. *International Journal of Drug Policy*, *27*, 89-96. https://doi.org/10.1016/j.drugpo.2015.08.003

COMBINE Study Research Group. (2003). Testing combined pharmacotherapies and behavioral interventions in alcohol dependence: rationale and methods. *Alcoholism: Clinical and Experimental Research*, *27*(7), 1107-1122. https://doi.org/10.1111/j.1530-0277.2003.tb02873.x

Commission on Alcohol Harm (2021, April 19). *'It's Everywhere' — Alcohol's Public Face and Private Harm.* https://lordslibrary.parliament.uk/commission-on-alcohol-harm-its-everywhere-alcohols-public-face-and-private-harm/

Copeland, A., Jones, A., & Field, M. (2020). The association between meaning in life and harmful drinking is mediated by individual differences in self-control and alcohol value. *Addictive behaviors reports*, *11*, 100258. https://doi.org/10.1016/j.abrep.2020.100258

Copello, A., & Orford, J. (2002). Addiction and the family: is it time for services to take notice of the evidence? *Addiction (Abingdon, England)*, *97*(11), 1361–1363. https://doi.org/10.1046/j.1360-0443.2002.00259.x

Copello, A., Orford, J., Hodgson, R., Tober, G., & Barrett, C. (2002). Social behaviour and network therapy: Basic principles and early experiences. *Addictive Behaviors*, *27*(3), 345–366. https://doi.org/10.1016/S0306-4603(01)00176-9

Copello, A., Orford, J., Hodgson, R., & Tober, G. (2009). *Social behaviour and network therapy for alcohol problems*. Routledge.

Copello, A., Velleman, R. D., & Templeton, L. J. (2005). Family interventions in the treatment of alcohol and drug problems. *Drug and alcohol review*, *24*(4), 369-385. https://doi.org/10.1080/09595230500302356

Copello, A., Williamson, E., Orford, J., & Day, E. (2006). Implementing and evaluating Social Behaviour and Network Therapy in drug treatment practice in the UK: A feasibility study. *Addictive Behaviors*, *31*(5), 802–810. https://doi.org/10.1016/j.addbeh.2005.06.005

Costello, S. J. (2016). The spirit of logotherapy. *Religions*, *7*(3), 2-12. https://doi.org/10.3390/rel7010003

Cotton Bronk, K., Hill, P. L., Lapsley, D. K., Talib, T. L., & Finch, H. (2009). Purpose, hope, and life satisfaction in three age groups. *The Journal of Positive Psychology*, *4*(6), 500-510. https://doi.org/10.1080/17439760903271439

Cowart, M. E., & Sutherland, M. (1998). Late-life drinking among women. *Geriatric Nursing (New York, NY)*, *19*(4), 214-219. https://doi.org/10.1016/s0197-4572(98)90155-0

Cranford, J. A., Krentzman, A. R., Mowbray, O., & Robinson, E. A. (2014). Trajectories of alcohol use over time among adults with alcohol dependence. *Addictive behaviors*, *39*(5), 1006-1011. https://doi.org/10.1016/j.addbeh.2014.02.009

Crewdson, J. A. (2016). The effect of loneliness in the elderly population: a review. *Healthy Aging & Clinical Care in the Elderly*, *8*, 1. https://doi.org/10.4137/HACCE.S35890

Crisp, R. (Ed.). (2014). *Aristotle: Nicomachean Ethics*. Cambridge University Press.

Critical Appraisal Skills Programme (2020). CASP Checklists. CASP Cohort Study Checklist. https://casp-uk.net/wp-content/uploads/2018/03/CASP-Cohort-Study-Checklist-2018_fillable_form.pdf

Crome, I. B., & Crome, P. (2018). Alcohol and age. *Age and ageing*, *47*(2), 164-167. https://doi.org/10.1093/ageing/afx191

Crouch, T. B., DiClemente, C. C., & Pitts, S. C. (2015). End-of-treatment abstinence self-efficacy, behavioral processes of change, and posttreatment drinking outcomes in Project MATCH. *Psychology of Addictive Behaviors*, *29*(3), 706. http://dx.doi.org/10.1037/adb0000086

Crumbaugh, J. C. (1968). Cross-validation of purpose-in-life test based on Frankl's concepts. *Journal of individual psychology*, *24*(1), 74.

Crumbaugh, J. C. (1981). Logotherapy: New help for problem drinkers. *International Forum for Logotherapy, 4*(1), 29–34.

Crumbaugh, J. C., & Carr, G. L. (1979). Treatment of alcoholics with logotherapy. *International Journal of the Addictions*, *14*(6), 847-853. https://doi.org/10.3109/10826087909041913

Crumbaugh, J. C., & Maholick, L. T. (1964). An experimental study in existentialism: The psychometric approach to Frankl's concept of noogenic neurosis. *Journal of clinical psychology*, *20*(2), 200-207. https://doi.org/10.1002/1097-4679(196404)20:2<200::AID-JCLP2270200203>3.0.CO;2-U

Csabonyi, M., & Phillips, L. J. (2020). Meaning in life and substance use. *Journal of Humanistic Psychology*, *60*(1), 3-19. https://doi.org/10.1177/0022167816687674

Cservenka, A., Fair, D. A., & Nagel, B. J. (2014). Emotional processing and brain activity in youth at high risk for alcoholism. *Alcoholism: Clinical and Experimental Research*, *38*(7), 1912-1923. https://doi.org/10.1111/acer.12435

Cummings, S. M., Bride, B., & Rawlins-Shaw, A. M. (2006). Alcohol abuse treatment for older adults: A review of recent empirical research. *Journal of evidence-based Social Work*, *3*(1), 79-99. https://doi.org/10.1300/J394v03n01_05

Dar, K. (2006). Alcohol use disorders in elderly people: fact or fiction?. *Advances in Psychiatric Treatment*, *12*(3), 173-181. https://doi.org/10.1192/apt.12.3.173

Das, A. K. (1998). Frankl and the realm of meaning. *The Journal of Humanistic Education and Development*, *36*(4), 199-211. https://doi.org/10.1002/j.2164-4683.tb00392.x

Dauber, H., Pogarell, O., Kraus, L., & Braun, B. (2018). Older adults in treatment for alcohol use disorders: service utilisation, patient characteristics and treatment outcomes. *Substance abuse treatment, prevention, and policy*, *13*(1), 40. https://doi.org/10.1186/s13011-018-0176-z

Davies, J. B. (1989). Drinking in England and Wales: the latest news from OPCS. *British Journal of Addiction*, *84*(9), 957-959. https://doi.org/10.1111/j.1360-0443.1989.tb00773.x

Davies, J. B. (1987). Questions and answers in addiction research. *British journal of addiction*, *82*(12), 1273-1276. https://doi.org/10.1111/j.1360-0443.1987.tb00428.x

Davies, J. B. (1997). *The myth of addiction*. Psychology Press.

Del Boca, F. K., & Noll, J. A. (2000). Truth or consequences: The validity of self-report data in health services research on addictions. Addiction, 95 (Suppl3), S347–S360. https://doi.org/10.1046/j.1360-0443.95.11s3.5.x

Department of Health (DoH), Welsh Government, Department of Health NI, Scottish Government. (2016). *UK chief medical Officers' low risk drinking guidelines*. https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking

DePue, M. K., Finch, A. J., & Nation, M. (2014). The bottoming-out experience and the turning point: A phenomenology of the cognitive shift from drinker to nondrinker. *Journal of addictions & offender counseling*, *35*(1), 38-56.

DiBartolo, M. C., & Jarosinski, J. M. (2017). Alcohol use disorder in older adults: challenges in assessment and treatment. *Issues in mental health nursing*, *38*(1), 25-32. https://doi.org/10.1080/01612840.2016.1257076

DiClemente, C. C., Carbonari, J. P., Montgomery, R. P., & Hughes, S. O. (1994). The Alcohol Abstinence Self-Efficacy scale. *Journal of studies on alcohol*, *55*(2), 141-148. https://doi.org/10.15288/jsa.1994.55.141

Dillons. (1990). Modern English Dictionary. Harper Collins Publishers Ltd.

Dingle, G. A., Cruwys, T., & Frings, D. (2015). Social identities as pathways into and out of addiction. *Frontiers in psychology*, *6*, 1795. https://doi.org/10.3389/fpsyg.2015.01795

Dodes, L., & Dodes, Z. (2015). *The sober truth: Debunking the bad science behind 12-step programs and the rehab industry*. Beacon Press.

Dollah, S., Abduh, A., & Rosmaladewi, M. (2017, September). Benefits and drawbacks of NVivo QSR application. In *2nd International Conference on Education, Science, and Technology (ICEST 2017)* (pp. 61-63). Atlantis Press. https://doi.org/10.2991/icest-17.2017.21

Doukas, N., & Cullen, J. (2009). Recovered, in recovery or recovering from substance abuse? A question of identity. *Journal of Psychoactive Drugs*, *41*(4), 391-394. https://doi.org/10.1080/02791072.2009.10399778

Doyle, L., Brady, A. M., & Byrne, G. (2009). An overview of mixed methods research. *Journal of research in nursing*, *14*(2), 175-185. https://doi.org/10.1177/1744987108093962

Dragišić Labaš, S. (2016). Alcohol use: social aspect, gender differences and stigmatization. *Alcoholism and psychiatry research: Journal on psychiatric research and addictions*, *52*(1), 51-64. https://doi.org/hrcak.srce.hr/160023

Drink Wise, Age Well. (2019, June). *Calling time for change: A charter to support all older adults in England to live free from the harm caused by alcohol.* https://www.drinkwiseagewell.org.uk/media/publications/pdfs/calling-time-for-change-england.pdf

Droller, H. (1964). Some aspects of alcoholism in the elderly. *The Lancet*, *284*(7351), 137-139. https://doi.org/10.1016/S0140-6736(64)90143-6

Drummond, C., McBride, O., Nicola, F., & Elizabeth, F. (2016). *Alcohol dependence*. https://pure.ulster.ac.uk/ws/files/11652785/Adult_psychiatric_study_CH10_WEB.pdf

Dunn, K. E., & Strain, E. C. (2013). Pretreatment Alcohol Drinking Goals are Associated with Treatment Outcomes. *Alcoholism, Clinical and Experimental Research*, *37*(10), 1745–1752. https://doi.org/10.1111/acer.12137

Dupree, L. W., Broskowski, H., & Schonfeld, L. (1984). The Gerontology Alcohol Project: A behavioral treatment program for elderly alcohol abusers. *The Gerontologist*, *24*(5), 510-516. https://doi.org/10.1093/geront/24.5.510

Dupree, L. W., Broskowski, H., & Schonfeld, L. (1982). *The Gerontology Alcohol Project*: *An 18-month evaluation*. Symposium presented at the 28th meeting of the Southeastern Psychological Association, New Orleans.

Dupree, L. W., & Schonfeld, L. (1986). Alcohol assessment and treatment planning for alcohol abusers: A curriculum manual. *FMHI Publication series*, (109).

Dvorak, R. D., Sargent, E. M., Kilwein, T. M., Stevenson, B. L., Kuvaas, N. J., & Williams, T. J. (2014). Alcohol use and alcohol-related consequences: Associations with emotion regulation difficulties. *The American journal of drug and alcohol abuse*, *40*(2), 125-130. https://doi.org10.3109/00952990.2013.877920

Eatough, V., & Smith, J. A. (2006). I was like a wild wild person: Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*, *97*(4), 483-498. https://doi.org/10.1348/000712606X97831

Edwards, M., Best, D., Irving, J., & Andersson, C. (2018). Life in recovery: a families' perspective. *Alcoholism Treatment Quarterly*, *36*(4), 437-458. https://doi.org/10.1080/07347324.2018.1488553

Edwards, R. W., Thurman, P. J., & Beauvais, F. (2002). Patterns of alcohol use among ethnic minority adolescent women. In M. Galanter (Ed.), *Recent developments in alcoholism*, (Vol 12, pp. 369-386). Kluwer.

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. *The Sage handbook of qualitative research in psychology*, 193-209.

Ellis, D. A., Zucker, R. A., & Fitzgerald, H. E. (1997). The role of family influences in development and risk. *Alcohol Health and Research World*, *21*(3), 218.

Elvig, S. K., McGinn, M. A., Smith, C., Arends, M. A., Koob, G. F., & Vendruscolo, L. F. (2021). Tolerance to alcohol: A critical yet understudied factor in alcohol addiction. *Pharmacology Biochemistry and Behavior*, *204*, 173155. https://doi.org/10.1016/j.pbb.2021.173155

Emiliussen, J., Andersen, K., & Nielsen, A. S. (2017a). How do family pressure, health and ambivalence factor into entering alcohol treatment? Experiences of people aged 60 and older with alcohol use disorder. *Nordic Studies on Alcohol and Drugs*, *34*(1), 28-42. https://doi/10.1177/1455072516682639

Emiliussen, J., Andersen, K., & Nielsen, A. S. (2017b). How do older adults with very-late-onset alcohol use disorder define alcohol problems? Results from an interpretative phenomenological study. *Alcoholism Treatment Quarterly*, *35*(2), 151-164. https://doi.org/10.1080/07347324.2017.1288480

Emiliussen, J., Andersen, K., & Nielsen, A. S. (2017c). Why do some older adults start drinking excessively late in life? Results from an interpretative phenomenological study. *Scandinavian journal of caring sciences*, *31*(4), 974-983. https://doi.org/10.1111/scs.12421

Emiliussen, J., Andersen, K., Nielsen, A. S., Braun, B., & Bilberg, R. (2019). What do elderly problem drinkers aim for? Choice of goal for treatment among elderly treatment-seeking alcohol-dependent patients. *Nordic Studies on Alcohol and Drugs*, *36*(6), 511-521.https://doi/10.1177/1455072519852852

Emiliussen, J., Nielsen, A. S., & Andersen, K. (2017d). Identifying risk factors for late-onset (50+) alcohol use disorder and heavy drinking: a systematic review. *Substance Use & Misuse*, *52*(12), 1575-1588. https://doi.org/10.1080/10826084.2017.1293102

Engel, G. L. (1977). The Need for a New Medical Model: A challenge for biomedicine. Science, 196(4286), 129-136.

Epstein, E. E., Fischer-Elber, K., & Al-Otaiba, Z. (2007). Women, aging, and alcohol use disorders. *Journal of women & aging*, *19*(1-2), 31-48. https://doi.org/10.1300/J074v19n01_03

Eriksen, L. L., & Hoeck, B. (2022). The construction of meaning in alcohol addiction: A narrative study of socially excluded people's stories about alcohol. *Nordic Studies on Alcohol and Drugs*, *39*(1), 76-88. https://doi.org/10.1177/1455072521999220

Eriksson, M., & Lindström, B. (2005). Validity of Antonovsky's sense of coherence scale: a systematic review. *Journal of Epidemiology & Community Health*, *59*(6), 460-466. https://doi.org/10.1136/jech.2003.018085

Esping, A. (2018). Franklian Psychology as a Theory of Motivation. In: *Epistemology, ethics, and meaning in unusually personal scholarship* (163-177). Palgrave Macmillan. https://doi.org/10.1007/978-3-319-73718-8_9

Eysenck, H. J., & Eysenck, S. G. B. (1965). The Eysenck personality inventory. *British Journal of Educational Studies*, *14*(1). https://doi.org/10.2307/3119050

Fan, A. Z., Chou, S. P., Zhang, H., Jung, J., & Grant, B. F. (2019). Prevalence and correlates of past-year recovery from DSM-5 alcohol use disorder: results from National Epidemiologic Survey on Alcohol and Related Conditions-III. *Alcoholism: clinical and experimental research*, *43*(11), 2406-2420. https://doi.org/10.1111/acer.14192

Farmer, R., & Sundberg, N. D. (1986). Boredom proneness--the development and correlates of a new scale. *Journal of personality assessment*, *50*(1), 4-17. https://doi.org/10.1207/s15327752jpa5001_2

Feldman, D. B., & Snyder, C. R. (2005). Hope and the meaningful life: Theoretical and empirical associations between goal–directed thinking and life meaning. *Journal of social and clinical psychology*, *24*(3), 401-421. https://doi.org/10.1521/jscp.24.3.401.65616

Fingerhood, M. (2000). Substance abuse in older people. *Journal of the American Geriatrics Society*, *48*(8), 985-995. https://doi.org/10.1111/j.1532-5415.2000.tb06900.x

Finlayson, R. E., Hurt, R. D., Davis Jr., L. J., & Morse, R. M. (1988). Alcoholism in elderly persons: a study of the psychiatric and psychosocial features of 216 inpatients. In *Mayo Clinic Proceedings*, *63*(8), 761-768. Elsevier. https://doi.org/10.1016/S0025-6196(12)62355-6

Finney J.W., Moos R.H. (1984) Life Stressors and Problem Drinking among Older Adults. In: Galanter M. et al. (eds) Recent Developments in Alcoholism. Springer, Boston, MA. https://doi.org/10.1007/978-1-4684-4661-6_15

Finney, J. W., Moos, R. H., & Brennan, P. L. (1991). The Drinking Problems Index: A measure to assess alcohol-related problems among older adults. *Journal of substance abuse*, *3*(4), 395-404. https://doi.org/10.1002/9780470479216.corpsy0573

Fitzgerald, J. L., & Mulford, H. A. (1992). Elderly vs. younger problem drinker 'treatment' and recovery experiences. *British journal of addiction*, *87*(9), 1281-1291. https://doi.org/10.1111/j.1360-0443.1992.tb02737.x

Flaherty, M. T., Kurtz, E., White, W. L., & Larson, A. (2014). An interpretive phenomenological analysis of secular, spiritual, and religious pathways of long-term addiction

recovery. *Alcoholism Treatment Quarterly*, *32*(4), 337-356. https://doi.org/10.1080/07347324.2014.949098

Forcehimes, A. A. (2004). De profundis: spiritual transformations in Alcoholics Anonymous. *Journal of Clinical Psychology*, *60*(5), 503-517. https://doi:10.1002/jclp.20004.

Fortney, J., Mukherjee, S., Curran, G., Fortney, S., Han, X., & Booth, B. M. (2004). Factors associated with perceived stigma for alcohol use and treatment among at-risk drinkers. The Journal of Behavioral Health Services & Research, 31(4), 418–429. https://doi.org/10.1007/bf02287693

Frankl, V. E. (1966). Logotherapy and existential analysis—a review. *American Journal of Psychotherapy*, *20*(2), 252-260. https://doi.org/10.1176/appi.psychotherapy.1966.20.2.252

Frankl, V. E. (1963). *Man's search for meaning*. Beacon Press.

Frankl, V. E. (2005). *On the theory and therapy of mental disorders: An introduction to logotherapy and existential analysis*. Routledge.

Frankl, V. E. (1969). *The doctor and the soul.* Souvenir Press.

Frankl, V. E. (1972). *The Feeling of Meaninglessness:* A Challenge to Psychotherapy. *American Journal of Psychoanalysis, 32*(1), 85. https://www.proquest.com/scholarly-journals/feeling-meaninglessness-challenge-psychotherapy/docview/1301646716/se-2

Frankl, V. E. (2014). *The will to meaning, expanded edition: Foundations and applications of logotherapy.* Penguin.

Frankl, V. E. (2011). *The unheard cry for meaning: Psychotherapy and humanism*. Simon and Schuster.

Frezza, M., di Padova, C., Pozzato, G., Terpin, M., Baraona, E., & Lieber, C. S. (1990). High blood alcohol levels in women: the role of decreased gastric alcohol dehydrogenase activity and first-pass metabolism. *New England Journal of Medicine*, *322*(2), 95-99. https://doi.org/10.1056/NEJM199001113220205

Frings, D., Collins, M., Long, G., Pinto, I. R., & Albery, I. P. (2016). A test of the Social Identity Model of Cessation Maintenance: The content and role of social control. *Addictive behaviors reports*, *3*, 77-85. https://doi.org/10.1016/j.abrep.2016.02.003

Galanter, M. (1990). Cults and zealous self-help movements. *American Journal of Psychiatry*, *145*(4), 543-551.

Galanter, M. (2007). Spirituality and recovery in 12-step programs: An empirical model. *Journal of Substance Abuse Treatment*, *33*(3), 265-272. https://doi.org/10.1016/j.jsat.2007.04.016

Galanter, M., White, W. L., & Hunter, B. (2023). Internal and External Resources Relied on by Established Twelve Step Fellowship Members for Their Recoveries. *Substance Use & Misuse*, *58*(1), 139-145. https://doi.org/10.1080/10826084.2022.2151311

Gardner, P. J., & Poole, J. M. (2009). One story at a time: Narrative therapy, older adults, and addictions. *Journal of Applied Gerontology*, *28*(5), 600-620. https://doi.org/10.1177/0733464808330822

Garnett, C., Jackson, S., Oldham, M., Brown, J., Steptoe, A., & Fancourt, D. (2021). Factors associated with drinking behaviour during COVID-19 social distancing and lockdown among adults in the UK. *Drug and alcohol dependence*, *219*, 108461. https://doi.org/10.1016/j.drugalcdep.2020.108461

Gell, L., Meier, P. S., & Goyder, E. (2015). Alcohol consumption among the over 50s: international comparisons. *Alcohol and alcoholism*, *50*(1), 1-10. https://doi.org/10.1093/alcalc/agu082

Gergen, M. M., & Gergen, K. J. (2001). Positive aging: New images for a new age. *Ageing International*, *27*(1), 3-23. https://doi.org/10.1007/s12126-001-1013-6

Gerrits, M. M., van Marwijk, H. W., van Oppen, P., van der Horst, H., & Penninx, B. W. (2015). Longitudinal association between pain, and depression and anxiety over four years. *Journal of psychosomatic research*, *78*(1), 64-70. https://doi.org/10.1016/j/jpsychores.2014.10.011

Gerwood, J. B. (1998). The existential vacuum in treating substance-related disorders. *Psychological reports*, *83*(3_suppl), 1394-1394. https://doi.org/10.2466/pr0.1998.83.3f.1394

Gilson, K. M., Bryant, C., & Judd, F. (2017). Understanding older problem drinkers: The role of drinking to cope. *Addictive behaviors*, *64*, 101-106. https://doi.org/10.1016/j.addbeh.2016.08.032

Giordano, J. A., & Beckham, K. (1985). Alcohol use and abuse in old age: an examination of type II alcoholism. *Journal of Gerontological Social Work*, *9*(1), 65-83. https://doi.org/10.1300/J083V09N01_06

Glassman, H. S., Moensted, M., Rhodes, P., & Buus, N. (2022a). The politics of belonging in Alcoholics Anonymous: A qualitative interview study. *American Journal of Community Psychology*, *70*(1-2), 33-44. https://doi.org/10.1002/ajcp.12568

Glassman, H. S., Rhodes, P., & Buus, N. (2020). A critical review of qualitative interview studies with Alcoholics Anonymous members. *Substance Use & Misuse*, *55*(3), 387-398. https://doi.org/10.1080/10826084.2019.1681450

Glassman, H. S., Rhodes, P., & Buus, N. (2022b). Exiting Alcoholics Anonymous disappointed: A qualitative analysis of the experiences of ex-members of AA. *Health*, *26*(4), 411-430. https://doi.org/10.1177/1363459320961438

Glatt, M. M. (1974). *A Guide to Addiction and its Treatment*. Medical and Technical Publishing Co. Limited.

Glatt, M. M. (1955). A treatment centre for alcoholics in a public mental hospital: its establishment and its working. *British Journal of Addiction to Alcohol & Other Drugs*, *52*(1-2), 55-89. https://doi.org/10.1111/j.1360-0443.1955.tb04682.x

Glatt, M. M. (1958). Group therapy in alcoholism. *British Journal of Addiction, 54*(2), 133-148. https://doi.org/10.1111/j.1360-0443.1958.tb04266.x

Glatt, M. M. (1970). *The alcoholic and the help he needs. Part 2. Treatment.* Medical and Technical Publishing Co. Limited.

Glatt, M. M. (1991). Warlingham and Minnesota compared. *British Journal of Addiction*, *86*(1), 19-20. https://doi.org/10.1111/j.1360-0443.1991.tb02621.x

Glatt, M. M., Rosin, A. J., & Jauhar, P. (1978). Alcoholic problems in the elderly. *Age and ageing*, *7*(suppl), 64-71. https://doi.org/10.1093/ageing/7.suppl.64

Glazer, S., Kozusznik, M. W., Meyers, J. H., & Ganai, O. (2014). Meaningfulness as a resource to mitigate work stress. In R. Sinclair & S. Leka (Eds.). *Contemporary Occupational Health Psychology: Global Perspectives on Research and Practice, 3*, 114-130. https://doi.org/10.1002/9781118713860.ch8

Gomes, K., & Hart, K. E. (2009). Adherence to recovery practices prescribed by Alcoholics Anonymous: Benefits to sustained abstinence and subjective quality of life. *Alcoholism Treatment Quarterly*, *27*(2), 223-235. https://doi.org/10.1080/07347320902784874

Gøtzsche, P. C. (2000). Why we need a broad perspective on meta-analysis: it may be crucially important for patients. https://doi.org/10.1136/bmj.321.7261.585

Gov.UK. (2023, September, 8). Office for Health Improvement & Disparities. *Part 1: introducing recovery, peer support and lived experience initiatives*. https://www.gov.uk/government/publications/recovery-support-services-and-lived-experience-initiatives/part-1-introducing-recovery-peer-support-and-lived-experience-initiatives

Granfield, R., & Cloud, W. (1999). *Coming clean: Overcoming addiction without treatment*. NYU press.

Granfield, R., & Cloud, W. (2001). Social context and "natural recovery": The role of social capital in the resolution of drug-associated problems. *Substance use & misuse*, *36*(11), 1543-1570. https://doi.org/10.1081/JA-100106963

Greaves, L. (2020). Missing in action: sex and gender in substance use research. *International journal of environmental research and public health, 17*(7), 2352. https://doi.org/10.3390/ijerph17072352

Green, C. A. (2006). Gender and use of substance abuse treatment services. *Alcohol Research & Health*, *29*(1), 55.

Greenfield, B. L., Venner, K. L., Kelly, J. F., Slaymaker, V., & Bryan, A. D. (2012). The impact of depression on abstinence self-efficacy and substance use outcomes among emerging adults in residential treatment. *Psychology of Addictive Behaviors*, *26*(2), 246. https://doi.org/10.1037/a0026917

Groshkova, T., & Best, D. (2011). The evolution of a UK evidence base for substance misuse recovery. *Journal of Groups in Addiction & Recovery*, *6*, 20–37. 10.1080/1556035X.2011.571135

Grosso, J. A., Epstein, E. E., McCrady, B. S., Gaba, A., Cook, S., Backer-Fulghum, L. M., & Graff, F. S. (2013). Women's motivators for seeking treatment for alcohol use disorders. Addictive Behaviors, *38*(6), 2236–2245. https://doi.org/:10.1016/j.addbeh.2013.02.004

Gubi, P. M., & Marsden-Hughes, H. (2013). Exploring the processes involved in long-term recovery from chronic alcohol addiction within an abstinence-based model: Implications for practice. *Counselling and Psychotherapy Research*, *13*(3), 201–209. https://doi.org/10.1080/14733145.2012.733716

Haeny, A. M., Littlefield, A. K., Wood, P. K., & Sher, K. J. (2018). Method effects of the relation between family history of alcoholism and parent reports of offspring impulsive behavior. *Addictive Behaviors*, *87*, 251–259. https://doi.org/10.1016/j.addbeh.2018.07.022

Hagman, B. T., Falk, D., Litten, R., & Koob, G. F. (2022). Defining recovery from alcohol use disorder: development of an NIAAA research definition. *American Journal of Psychiatry*, *179*(11), 807-813. https://doi.org/10.1176/appi.ajp.21090963

Haighton, C., Steer, M., & Nichol, B. (2024). Domiciliary Carers' Perspectives on Alcohol Use by Older Adults in Their Care: A Systematic Review and Thematic Synthesis of Qualitative Studies. *International Journal of Environmental Research and Public Health*, *21*(10), 1324-. https://doi.org/10.3390/ijerph21101324

Hammarlund, R., Crapanzano, K. A., Luce, L., Mulligan, L., & Ward, K. M. (2018). Review of the effects of self-stigma and perceived social stigma on the treatment-seeking decisions of individuals with drug-and alcohol-use disorders. *Substance abuse and rehabilitation*, *9*, 115. https://doi.org/102147/SAR.S183256

Hanson, B. S. (1994). Social network, social support and heavy drinking in elderly men-a population study of men born in 1914, Malmö, Sweden. *Addiction (Abingdon, England)*, *89*(6), 725–732. https://doi.org/10.1111/j.1360-0443.1994.tb00958.x

Harlow, L. L., Newcomb, M. D., & Bentler, P. M. (1987). Purpose in Life Test assessment using latent variable methods. *British Journal of Clinical Psychology*, *26*(3), 235-236. https://doi.org/10.1111/j.2044-8260.1987.tb01355.x

Hart, K. E., & Singh, T. (2009). An existential model of flourishing subsequent to treatment for addiction: The importance of living a meaningful and spiritual life. *Illness, crisis & loss*, *17*(2), 125-147. https://doi.org/10.2190/IL.17.2.d

Haslam, S. A. (2014). Making good theory practical: Five lessons for an applied social identity approach to challenges of organizational, health, and clinical psychology. *British journal of social psychology*, *53*(1), 1-20.

Hecksher, D., & Hesse, M. (2009). Women and substance use disorders. *Mens sana monographs*, *7*(1), 50. https://doi/10.4103/0973-1229.42585

Hedayati, M. M., & Khazaei, M. M. (2014). An investigation of the relationship between depression, meaning in life and adult hope. *Procedia-Social and Behavioral Sciences*, *114*, 598-601. https://doi.org/10.1016/j.sbspro.2013.12.753

Heidegger, M. (1977). Basic Writings: From Being and Time (1927) to the Task of Thinking (1964). Harper Perennial Modern Thought.

Heinsch, M., Sampson, D., Huens, V., Handley, T., Hanstock, T., Harris, K., & Kay-Lambkin, F. (2020). Understanding ambivalence in help-seeking for suicidal people with comorbid depression and alcohol misuse. *PloS One*, *15*(4), e0231647–e0231647. https://doi.org/10.1371/journal.pone.0231647

Hennessy, E. A. (2017). Recovery capital: a systematic review of the literature. *Addiction Research & Theory*, *25*(5), 349–360. https://doi.org/10.1080/16066359.2017.1297990

Henning, G., Lindwall, M., & Johansson, B. (2016). Continuity in well-being in the transition to retirement. *GeroPsych*. https://doi.org/10.1024/1662-9647/a000155

Henrion, R. (2002). Alcohol use disorders: Alcohol dependence. *International Forum for Logotherapy*, *25*(1), 30-38.

Henrion, R. (1987). Making logotherapy a reality in treating alcoholics. *International Forum for Logotherapy*. *10*, (2), 112-117.

Hirschle, J. (2010). From religious to consumption-related routine activities? Analyzing Ireland's economic boom and the decline in church attendance. *Journal for the scientific study of religion*, *49*(4), 673-687. https://doi.org/10.1111/j.1468-5906.2010.01536.x

Holahan, C. J., Moos, R. H., Holahan, C. K., Brennan, P. L., & Schutte, K. K. (2005). Stress generation, avoidance coping, and depressive symptoms: a 10-year model. *Journal of consulting and clinical psychology*, *73*(4), 658. https://doi.org/10.1037/0022-006X.73.4.658

Holland, M. G., & Ferner, R. E. (2017). A systematic review of the evidence for acute tolerance to alcohol–the "Mellanby effect". *Clinical toxicology*, *55*(6), 545-556. https://doi.org/10.1080/15563650.2017.1296576

Holley-Moore, G., & Beach, B. (2016). *Drink wise, age well: alcohol use and the over 50s in the UK*. International Longevity Centre-UK.

Holton, A. E., Gallagher, P., Fahey, T., & Cousins, G. (2017). Concurrent use of alcohol interactive medications and alcohol in older adults: a systematic review of prevalence and associated adverse outcomes. *BMC Geriatrics*, *17*(1), 148–148. https://doi.org/10.1186/s12877-017-0532-2

Howie, L., Coulter, M., & Feldman, S. (2004). Crafting the self: Older persons' narratives of occupational identity. *The American journal of occupational therapy*, *58*(4), 446-454. https://doi.org/10.5014/ajot.58.4.446

Huffine, C. L., Folkman, S., & Lazarus, R. S. (1989). Psychoactive drugs, alcohol, and stress and coping processes in older adults. *The American journal of drug and alcohol abuse*, *15*(1), 101-113. https://doi.org/10.3109/00952998908993403

Humphreys, K. (2004) *Circles of Recovery: Self-Help Organizations for Addictions,* Cambridge: Cambridge University Press.

Humphreys, K. (2000). Community narratives and personal stories in Alcoholics Anonymous. *Journal of community psychology*, *28*(5), 495-506. https://doi.org/10.1002/1520-6629(200009)28:5<495::AID-JCOP3>3.0.CO;2-W

Humphreys, K., & Klaw, E. (2001). Can targeting nondependent problem drinkers and providing internet-based services expand access to assistance for alcohol problems? A study of the moderation management self-help/mutual aid organization. *Journal of studies on alcohol*, *62*(4), 528-532. https://doi.org/10.15288/jsa.2001.62.528

Humphreys, K., & Lembke, A. (2014). Recovery-oriented policy and care systems in the UK and USA. *Drug and alcohol review*, *33*(1), 13-18. https://doi.org/10.1111/dar.12092

Husserl, E. (1999). *The essential Husserl: Basic writings in transcendental phenomenology*. Indiana University Press.

Husserl, E. (1900). The shorter logical investigations. *Logische Untersuchungen (2nd ed.). London and New York: Taylor & Francis Group*.

Hutzell, R. R. (1984). Logoanalysis for alcoholics. *International Forum for Logotherapy, 7*(1), 40–45.

Huurre, T., Lintonen, T., Kaprio, J., Pelkonen, M., Marttunen, M., & Aro, H. (2010). Adolescent risk factors for excessive alcohol use at age 32 years. A 16-year prospective follow-up study. *Social psychiatry and psychiatric epidemiology*, *45*, 125-134. htpps://doi.org/ 10.1007/s00127-009-0048-y

Ilgen, M., McKellar, J., & Moos, R. (2007). Personal and treatment-related predictors of abstinence self-efficacy. *Journal of Studies on Alcohol and Drugs*, *68*(1), 126-132. https://doi.org/10.15288/jsad.2007.68.126

Ilgen, M., McKellar, J., & Tiet, Q. (2005). Abstinence Self-Efficacy and Abstinence 1 Year After Substance Use Disorder Treatment. *Journal of Consulting and Clinical Psychology*, *73*(6), 1175–1180. https://doi.org/10.1037/0022-006X.73.6.1175

Ilgen, M., Tiet, Q., Finney, J., & Moos, R. H. (2006). Self-efficacy, therapeutic alliance, and alcohol-use disorder treatment outcomes. *Journal of studies on alcohol*, *67*(3), 465-472. https://doi.org/10.15288/jsa.2006.67.465

Immonen, S., Valvanne, J., & Pitkälä, K. H. (2011). Older adults' own reasoning for their alcohol consumption. *International journal of geriatric psychiatry*, *26*(11), 1169-1176. https://doi.org/10.1002/gps.2657

Inglehart, R. F. (2020, September-October). Giving Up on God: The Global Decline of Religion. *Foreign Affairs*, *99*(5), 110+. https://link.gale.com/apps/doc/A632961656/AONE?u=tasc&sid=bookmark-AONE&xid=78d49ab6

Ingram, I., Kelly, P. J., Deane, F. P., Baker, A. L., Goh, M. C. W., Raftery, D. K., & Dingle, G. A. (2020). Loneliness among people with substance use problems: A narrative systematic review. *Drug and Alcohol Review*, *39*(5), 447–483. https://doi.org/10.1111/dar.13064

Institute of Alcohol Studies. (2021, August 26). *Alcohol Alert — August 2021*. https://instalcstud.substack.com/p/alcohol-alert-august-2021

International Statistical Classification of Diseases and Related Health Problems – 10th revision. (2019). *Chapter V. Mental and behavioural disorders (F00-F99).Mental and behavioural*

disorders due to psychoactive substance use (F10-F19). ICD-10 Version:2019. https://icd.who.int/browse10/2019/en#/F10.2

Iparraguirre, J. (2015). Socioeconomic determinants of risk of harmful alcohol drinking among people aged 50 or over in England. *BMJ open*, *5*(7), e007684. https://doi.org/10.1136/bmjopen-2015-007684

Irving, A. D. (2011). Life story narratives of recovery from dependent drug and alcohol use: a tool for identity reconstruction within a therapeutic community. *Therapeutic Communities: the International Journal of Therapeutic Communities*, *32*(3), 182-200.

Iyer, A., Jetten, J., Tsivrikos, D., Postmes, T., & Haslam, S. A. (2009). The more (and the more compatible) the merrier: Multiple group memberships and identity compatibility as predictors of adjustment after life transitions. *British Journal of Social Psychology*, *48*(4), 707-733. https://doi.org/10.1348/014466608X397628

Jacobs, L., & Jacobs, J. (2015). "Fixing" Mother's who Drink: Family Narratives on Secrecy, Shame and Silence. *The Open Family Studies Journal*, *7*(1), 28–33. https://doi.org/10.2174/1874922401507010028

Jacobson, G. R., Ritter, D. P., & Mueller, L. (1977). Purpose in life and personal values among adult alcoholics. *Journal of Clinical Psychology*, *33*(S1), 314-316.

Jakubczyk, A., Trucco, E. M., Kopera, M., Kobyliński, P., Suszek, H., Fudalej, S., ... & Wojnar, M. (2018). The association between impulsivity, emotion regulation, and symptoms of alcohol use disorder. *Journal of substance abuse treatment*, *91*, 49-56. https://doi.org/10.1016/j.jsat.2018.05.004

Jellinek, E. M. (1946). Phases in the drinking history of alcoholics. Analysis of a survey conducted by the official organ of Alcoholics Anonymous (Memoirs of the Section of Studies on Alcohol). *Quarterly journal of studies on alcohol*, *7*(1), 1-88. https://doi.org/10.15288/qjsa.1946.7.1

Jellinek, E. M. (1952). Phases of alcoholic addiction. *Quarterly journal of studies on alcohol*, *13*(4), 673-684. https://doi.org/10.15288/qjsa.1952.13.673

Jellinek, E. M. (1960). *The disease concept of alcoholism*. Hillhouse Press. https://doi.org/10.1037/14090-000

Johannessen, A., Tevik, K., Engedal, K., Tjelta, T., & Helvik, A. S. (2022). Family'members experiences of their older relative's alcohol and substance misuse. *International Journal of Qualitative Studies on Health and Well-being*, *17*(1), 2094059. https://doi.org/10.1080/17482631.2022.2094059

Johnson, I. (2000). Alcohol problems in old age: a review of recent epidemiological research. *International Journal of Geriatric Psychiatry*, *15*(7), 575–581. https://doi.org/10.1002/1099-1166(200007)15:7<575::AID-GPS151>3.0.CO;2-0

Jung, C. G. (1983). *Memories, dreams, reflections.* Flamingo.

Junior, V. (2006). Purpose and meaning in life relative to time in recovery from alcoholism. In *International Forum for Logotherapy*, *29*(2), 99-102.

Kang, Y., Strecher, V. J., Kim, E., & Falk, E. B. (2019). Purpose in life and conflict-related neural responses during health decision-making. *Health Psychology, 38*(6), 545–552. https://doi.org/10.1037/hea0000729

Katsogianni, I. V., & Kleftaras, G. (2015). Spirituality, Meaning in Life, and Depressive Symptomatology in Drug Addiction. *International Journal of Religion & Spirituality in Society*, *5*(2). https://www.researchgate.net/publication/268511923

Kaur, M., & Kaur, J. (2021). Reality therapy: a boon to recuperate from empty nest syndrome. *International Journal of Choice Theory and Reality Therapy*, *40*(2), 46-62.

Kelly, J. F. (2019). E. M. Jellinek's Disease Concept of Alcoholism. *Addiction*, *114*(3), 555–559. https://doi.org/10.1111/add.14400

Kelly, J. F., Dow, S. J., & Westerhoff, C. (2010). Does our choice of substance-related terms influence perceptions of treatment need? An empirical investigation with two commonly used terms. *Journal of Drug Issues*, *40*(4), 805-818. https://doi.org/10.1177/002204261004000403

Kelly, J. F., & Hoeppner, B. B. (2013). Does Alcoholics Anonymous work differently for men and women? A moderated multiple-mediation analysis in a large clinical sample. *Drug and alcohol dependence*, *130*(1-3), 186-193. https://doi.org/10.1016/j.drugalcdep.2012.11.005

Kelly, J. F., Saitz, R., & Wakeman, S. (2016). Language, substance use disorders, and policy: the need to reach consensus on an "addiction-ary". *Alcoholism Treatment Quarterly*, *34*(1), 116-123. https://doi.org/10.1080/07347324.2016.1113103

Kelly, J. F., Stout, R. L., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism, Clinical and Experimental Research*, *30*(8), 1381–1392. https://doi.org/10.1111/j.1530-0277.2006.00165

Kelly, S., Olanrewaju, O., Cowan, A., Brayne, C., & Lafortune, L. (2018a). Alcohol and older people: A systematic review of barriers, facilitators and context of drinking in older people and implications for intervention design. *PloS one*, *13*(1), e0191189. https://doi.org/10.1371/journal.pone.0191189

Kelly, S., Olanrewaju, O., Cowan, A., Brayne, C., & Lafortune, L. (2018b). Interventions to prevent and reduce excessive alcohol consumption in older people: a systematic review and meta-analysis. *Age and ageing*, *47*(2), 175-184. https://doi.org.ezproxy.derby.ac.uk/10.1093/ageing/afx132

Keyes, K. M., Allel, K., Staudinger, U. M., Ornstein, K. A., & Calvo, E. (2019). Alcohol consumption predicts incidence of depressive episodes across 10 years among older adults in 19 countries. International review of neurobiology, 148, 1-38 https://doi.org/10.1017/S1041610212000087

Keyes, K. M., Hatzenbuehler, M. L., McLaughlin, K. A., Link, B., Olfson, M., Grant, B., & Hasin, D. (2010). Stigma and treatment for alcohol disorders in the United States. American Journal of Epidemiology, 172(12), 1364–1372. doi:10.1093/aje/kwq304

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard review of psychiatry*, *4*(5), 231-244. https://doi.org/10.3109/10673229709030550

Khosravani, V., Sharifi Bastan, F., Avatefi, B., & Mofidi, F. (2018). Alexithymia influences craving through facets of emotion regulation in alcoholic patients. *Journal of Substance Use*, *23*(1), 29-35. https://doi.org/10.1080/14659891.2017.1333163

Khosravani, V., Bastan, F. S., Ghorbani, F., & Kamali, Z. (2017). Difficulties in emotion regulation mediate negative and positive affects and craving in alcoholic patients. *Addictive Behaviors*, *71*, 75-81. https://doi.org/10.1016/j.addbeh.2017.02.029

Kiecolt, K. J. (1994). Stress and the decision to change oneself: A theoretical model. *Social Psychology Quarterly*, 49-63. https://doi.org/10.2307/2786974

Kikumura, A. (1986). Family Life Histories: A collaborative Venture. In *The oral history reader*, *14*, 1-7.

Kim, E. S., Shiba, K., Boehm, J. K., & Kubzansky, L. D. (2020). Sense of purpose in life and five health behaviors in older adults. *Preventive medicine*, *139*, 106172. https://doi.org/10.1016/j.ypmed.2020.106172

Kim, E. S., Sun, J. K., Park, N., & Peterson, C. (2013). Purpose in life and reduced incidence of stroke in older adults: 'The Health and Retirement Study'. *Journal of psychosomatic research*, *74*(5), 427-432. http://dx.doi.org/10.1016/j.jpsychores.2013.01.013

Kim, C., & Choi, H. (2021). The efficacy of group logotherapy on community-dwelling older adults with depressive symptoms: A mixed methods study. *Perspectives in Psychiatric Care*, *57*(2), 920–928. https://doi.org/10.1111/ppc.12635

Kimble, M. A., & Ellor, J. W. (2001). Logotherapy: an overview. *Journal of religious gerontology*, *11*(3-4), 9-24. https://doi.org/10.1300/J078v11n03_03

Kime, K. G. (2018). Interpretive Phenomenological Analysis of the Spiritual Characteristics of Recovery Experiences in the Context of the Brain Disease Model of Addiction. *Pastoral psychology*, *67*(4), 357-372. https://doi.org/10.1007/s11089-018-0816-2

Kist, N., Sandjojo, J., Kok, R. M., & Van den Berg, J. F. (2014). Cognitive functioning in older adults with early, late, and very late onset alcohol dependence. *International psychogeriatrics*, *26*(11), 1863.https://doi/10.1017/S1041610214000878

Kleftaras, G., & Katsogianni, I. (2012). Spirituality, meaning in life, and depressive symptomatology in individuals with alcohol dependence. *Journal of Spirituality in Mental Health*, *14*(4), 268-288. https://doi.org/10.1080/19349637

Kleinig, J. (2008). Recovery as an Ethical Ideal: Special Issue on Recovery. *Substance Use & Misuse*, *43*(12-13), 1685-1703. https://doi.org/10.1080/10826080802293350

Kobayashi, L. C., & Steptoe, A. (2018). Social isolation, loneliness, and health behaviors at older ages: longitudinal cohort study. *Annals of Behavioral Medicine*, *52*(7), 582-593. https://doi.org/10.1093/abm/kax033

Koch, A. (2019). Long-Term Sustained Recovery from Alcohol Use Disorders Among Veterans: A Grounded Theory Investigation. *Journal of Veterans Studies*, *4*(2), 112.

Kokkevi, A., & Hartgers, C. (1995). EuropASI: European adaptation of a multidimensional assessment instrument for drug and alcohol dependence. *European addiction research*, *1*(4), 208-210. https://doi.org/10.1159/000259089

Kornreich, C., Brevers, D., Canivet, D., Ermer, E., Naranjo, C., Constant, E., ... & Noël, X. (2013). Impaired processing of emotion in music, faces and voices supports a generalized emotional decoding deficit in alcoholism. *Addiction*, *108*(1), 80-88. https://doi.org/10.1111/j.1360-0443.2012.03995.x

Kotchen, T. A. (1960). Existential mental health: An empirical approach. *Journal of Individual Psychology*, *16*(2), 174.

Kougiali, Z. G., Pytlik, A., & Soar, K. (2021). Mechanisms and processes involved in women's pathways into alcohol dependence and towards recovery: a qualitative meta-synthesis. *Drugs: Education, Prevention and Policy*, *28*(5), 437-453. https://doi.org/10.1080/09687637.2021.1904836

Krawczyk, N., Negron, T., Nieto, M., Agus, D., & Fingerhood, M. I. (2018). Overcoming medication stigma in peer recovery: A new paradigm. *Substance Abuse*, *39*(4), 404–409. https://doi.org/10.1080/08897077.2018.1439798

Krentzman, A. R. (2017). Gratitude, abstinence, and alcohol use disorders: Report of a preliminary finding. *Journal of Substance Abuse Treatment*, *78*, 30–36. https://doi.org/10.1016/j.jsat.2017.04.013

Krentzman, A. R., Cranford, J. A., & Robinson, E. A. (2015). Long-term increases in purpose in life are associated with remission from alcohol dependence. *Alcoholism Treatment Quarterly*, *33*(3), 252-269. https://doi.org/10.1080/07347324.2015.1050924

Krentzman, A. R., Strobbe, S., Harris, J. I., Jester, J. M., & Robinson, E. A. R. (2017). Decreased drinking and Alcoholics Anonymous are associated with different dimensions of spirituality. *Psychology of Religion and Spirituality, 9*(Suppl 1), S40–S48. https://doi.org/10.1037/rel0000121

Kruger, E. S., Serier, K. N., Pfund, R. A., McKay, J. R., & Witkiewitz, K. (2021). Integrative data analysis of self-efficacy in 4 clinical trials for alcohol use disorder. *Alcoholism: Clinical and Experimental Research*, *45*(11), 2347-2356. https://doi.org/10.1111/acer.14713

Kuerbis, A., Sacco, P., Blazer, D. G., & Moore, A. A. (2014). Substance abuse among older adults. *Clinics in geriatric medicine*, *30*(3), 629-654. https://doi.org/10.1016/j.cger.2014.04.008

Kuerbis, A., & Sacco, P. (2012). The impact of retirement on the drinking patterns of older adults: A review. *Addictive Behaviors*, *37*(5), 587–595. https://doi.org/10.1016/j.addbeh.2012.01.022

Kulik, W., & Shah, A. (2016). Role of peer support workers in improving patient experience in Tower Hamlets Specialist Addiction Unit. *BMJ Open Quality*, *5*(1), u205967-w2458. http://dx.doi.org/10.1136/bmjquality.u205967.w2458

Kuperman, S., Chan, G., Kramer, J. R., Bierut, L., Bucholz, K. K., Fox, L., ... & Schuckit, M. A. (2005). Relationship of age of first drink to child behavioral problems and family psychopathology. *Alcoholism: Clinical and Experimental Research*, *29*(10), 1869-1876. https://doi.org/10.1097/01.alc.0000183190.32692.c7

Kurtz, E. (2002). Alcoholics Anonymous and the disease concept of alcoholism. Alcoholism Treatment Quarterly, 20(3–4), 5–39. doi:10.1300/J020v20n03_02

Kurtz, E. (2010). *Not God: A history of Alcoholics Anonymous*. Simon and Schuster.

Lancaster, K., Seear, K., & Ritter, A. (2017). Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use. *Brisbane: Queensland Mental Health Commission*, *118*, 1-118.

Längle, A., Orgler, C., & Kundi, M. (2003). The Existence Scale: A new approach to assess the ability to find personal meaning in life and to reach existential fulfillment. *European Psychotherapy*, *4*(1), 135-151.

Latanioti, M., Schuster, J.-P., Rosselet Amoussou, J., Strippoli, M.-P. F., von Gunten, A., Ebbing, K., & Verloo, H. (2020). Epidemiology of at-risk alcohol use and associated comorbidities of interest among community-dwelling older adults: a protocol for a systematic review. *BMJ Open*, *10*(1), e035481-. https://doi.org/10.1136/bmjopen-2019-035481

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of substance abuse treatment*, *33*(3), 243-256. https://doi.org/10.1016/j.jsat.2007.04.014

Laudet, A. B., Morgen, K., & White, W. L. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug problems. *Alcoholism treatment quarterly*, *24*(1-2), 33-73. https://doi.org/10.1300/J020v24n01_04

Laudet, A. B., Savage, R., & Mahmood, D. (2002). Pathways to Long-Term Recovery: A Preliminary Investigation. *Journal of Psychoactive Drugs*, *34*(3), 305–311. https://doi.org/10.1080/02791072.2002.10399968

Laudet, A. B., & White, W. (2010). What are your priorities right now? Identifying service needs across recovery stages to inform service development. *Journal of Substance Abuse Treatment*, *38*(1), 51–59. https://doi.org/10.1016/j.jsat.2009.06.003

Lederman, L. C., & Menegatos, L. M. (2011). Sustainable recovery: The self-transformative power of storytelling in Alcoholics Anonymous. *Journal of Groups in Addiction & Recovery*, *6*(3), 206-227. https://doi.org/10.1080/1556035X.2011.597195

Leonard, K. E., & Eiden, R. D. (2007). Marital and family processes in the context of alcohol use and alcohol disorders. *Annu. Rev. Clin. Psychol.*, *3*, 285-310. https://doi: 10.1146/annurev.clinpsy.3.022806.091424

Leontiev, D. (2016). Logotherapy beyond psychotherapy: dealing with the spiritual dimension. In *Logotherapy and Existential Analysis: Proceedings of the Viktor Frankl Institute Vienna, Volume 1* (pp. 277-290). Springer International Publishing.

Le Strat, Y., Grant, B. F., Ramoz, N., & Gorwood, P. (2010). A new definition of early age at onset in alcohol dependence. *Drug and alcohol dependence*, *108*(1-2), 43-48. https://doi.org:10.1016/j.drugalcdep.2009.11.011

Le, T. M., Wang, W., Zhornitsky, S., Dhingra, I., Chen, Y., Zhang, S., & Li, C. S. R. (2021). The neural processes interlinking social isolation, social support, and problem alcohol use. *International Journal of Neuropsychopharmacology*, *24*(4), 333-343. https://doi.org/10.1093/ijnp/pyaa086

Lewis, N. A., & Hill, P. L. (2021). Sense of Purpose Promotes Resilience to Cognitive Deficits Attributable to Depressive Symptoms. *Frontiers in Psychology*, *12*, 698109–698109. https://doi.org/10.3389/fpsyg.2021.698109

Liang, W., & Chikritzhs, T. (2011). Affective disorders, anxiety disorders and the risk of alcohol dependence and misuse. *The British Journal of Psychiatry*, *199*(3), 219-224. https://doi.org/10.1192/bjp.bp.110.086116

Liberto, J. G., & Oslin, D. W. (1995). Early versus late onset of alcoholism in the elderly. *International Journal of the Addictions*, *30*(13-14), 1799-1818. https://doi.org/10.3109/10826089509071056

Lindfors, P., & Lundberg, U. (2002). Is low cortisol release an indicator of positive health?. *Stress and health: Journal of the International Society for the Investigation of Stress*, *18*(4), 153-160. https://doi.org/10.1002/smi.942

Lisansky Gomberg, E. S. (1988). Shame and guilt issues among women alcoholics. *Alcoholism treatment quarterly*, *4*(2), 139-155. https://doi.org/10.1300/J020v04n02_09

Lopez Gaston, R. S., Best, D., Day, E., & White, W. (2010). Perceptions of 12-step interventions among UK substance-misuse patients attending residential inpatient treatment in a UK treatment setting. *Journal of Groups in Addiction & Recovery*, *5*(3–4), 306–323. https://doi.org/10.1080/ 1556035X.2010.523371

Luca, M., Chisari, C. G., Zanghì, A., & Patti, F. (2021). Early-Onset Alcohol Dependence and Multiple Sclerosis: Diagnostic Challenges. *International Journal of Environmental Research and Public Health*, *18*(11), 5588. https://doi.org/10.3390/ijerph18115588

Lu, W., Kim, J. C., Yoon, A. S., Yun, K. K., & Solomon, P. (2022). Trends and disparities in unmet treatment needs for co-occurring depression and alcohol use disorders among young adults in the U.S. *American Journal of Orthopsychiatry*, *92*(3), 268–279. https://doi.org/10.1037/ort0000608

Lyons, G. C., Deane, F. P., & Kelly, P. J. (2010). Forgiveness and purpose in life as spiritual mechanisms of recovery from substance use disorders. *Addiction Research & Theory*, *18*(5), 528-543. https://doi.org/10.3109/16066351003660619

Maassen, E. F., Regeer, B. J., Regeer, E. J., Bunders, J. F., & Kupka, R. W. (2018). The challenges of living with bipolar disorder: a qualitative study of the implications for health care and research. *International journal of bipolar disorders*, *6*(1), 1-10. https://doi.org/10.1186/s40345-018-0131-y

Maclean, F., Dewing, J., Kantartzis, S., Breckenridge, J. P., & McCormack, B. (2022). Can we talk about it? A qualitative study exploring occupational therapists' decision making in judging when to ask an older person about drinking alcohol. *Ageing & Society*, *42*(3), 521-538. https://doi.org/10.1017/S0144686X20000951

Madden, M., Stewart, D., Mills, T., & McCambridge, J. (2023). Alcohol, the overlooked drug: clinical pharmacist perspectives on addressing alcohol in primary care. *Addiction science & clinical practice*, *18*(1), 1-10. https://doi.org/10.1186/s13722-023-00378-x

Magruder-Habib, K., Harris, K. E., & Fraker, G. G. (1982). Validation of the Veterans Alcoholism Screening Test. *Journal of Studies on Alcohol*, *43*(9), 910-926. https://doi.or/10.15288/jsa.1982.43.910

Maisto, S. A., Roos, C. R., O'Sickey, A. J., Kirouac, M., Connors, G. J., Tonigan, J. S., & Witkiewitz, K. (2015). The indirect effect of the therapeutic alliance and alcohol abstinence self-efficacy on alcohol use and alcohol-related problems in Project MATCH. *Alcoholism: Clinical and Experimental Research*, *39*(3), 504-513. https://doi.org/10.1111/acer.12649

Majer, J. M., Callahan, S., Stevick, K., & Jason, L. A. (2016). Social Influences on Abstinence Self-Efficacy Among Justice-Involved Persons. *Journal of social work practice in the addictions*, *16*(3), 252-265. https://doi.org/10.1080/1533256X.2016.1200054

Majer, J. M., Salina, D. D., & Jason, L. A. (2015). Social support among substance using women with criminal justice involvement. *Journal of forensic social work*, *5*(1-3), 116-129. https://doi.org/10.10180/1936928X.2015.1075167

Mamić, M., Gretzer, T., Zirdum, I., Vidić, H., Tomić, A., Mikšić, S., ... & Vukoja, I. (2024). Meaning of Life in Secondary Abstainers from Alcohol (Abstain From Alcohol and Meaning of Life). *Archives of Psychiatry Research: An International Journal of Psychiatry and Related Sciences*, *60*(2.), 99-107. https://doi.org/10.20471/june.2024.60.02.02

Mansfield, K., Crellin, E., Denholm, R., Quint, J. K., Smeeth, L., Cook, S., & Herrett, E. (2019). Completeness and validity of alcohol recording in general practice within the UK: a cross-sectional study. *BMJ open*, *9*(11), e031537. https://doi.org/ 10.1136/bmjopen-2019-031537

Marco, J. H., Alonso, S., & Baños, R. (2021). Meaning-making as a mediator of anxiety and depression reduction during cognitive behavioral therapy intervention in participants with adjustment disorders. *Clinical Psychology and Psychotherapy*, *28*(2), 325–333. https://doi.org/10.1002/cpp.2506

Marengo, D., Azucar, D., Giannotta, F., Basile, V., & Settanni, M. (2019). Exploring the association between problem drinking and language use on Facebook in young adults. *Heliyon*, *5*(10), e02523. https://doi.org/10.1016/j.heliyon.2019.e02523

Margolis, R., Kilpatrick, A., & Mooney, B. (2000). A Retrospective Look at Long-Term Adolescent Recovery: Clinicians Talk to Researchers. *Journal of Psychoactive Drugs*, *32*(1), 117–125. https://doi.org/10.1080/02791072.2000.10400217

Markel, H. (2010, April 19). The New York Times. Health: *An alcoholic's Savior: God, belladonna or both?* https://www.nytimes.com/2010/04/20/health/20drunk.html

Marlatt, G. A., & Witkiewitz, K. (2002). Harm reduction approaches to alcohol use: Health promotion, prevention, and treatment. *Addictive behaviors*, *27*(6), 867-886. https://doi.org/10.1016/S0306-4603(02)00294-0

Marlow, E., Grajeda, W., Lee, Y., Young, E., Williams, M., & Hill, K. (2015). Peer mentoring for male parolees: A CBPR pilot study. *Progress in Community Health Partnerships: Research, Education, and Action*, *9*(1), 91-100.

Marseille, J. (1997). The spiritual dimension in logotherapy: Viktor Frankl's contribution to transpersonal psychology. *The Journal of Transpersonal Psychology*, *29*(1), 1.

Marsh, A., Smith, L., Piek, J., & Saunders, B. (2003). The purpose in life scale: Psychometric properties for social drinkers and drinkers in alcohol treatment. *Educational and Psychological Measurement*, *63*(5), 859-871. https://doi.org/10.1177/0013164402251040

Marsiglia, F. F., Kulis, S., Parsai, M., Villar, P., & Garcia, C. (2009). Cohesion and conflict: Family influences on adolescent alcohol use in immigrant Latino families. *Journal of ethnicity in substance abuse*, *8*(4), 400-412. https://doi.org/10.1080/15332640903327526

Martin, C. S., & Moss, H. B. (1993). Measurement of acute tolerance to alcohol in human subjects. *Alcoholism: Clinical and Experimental Research*, *17*(2), 211-216. https://doi.org/10.1111/j.1530-0277.1993.tb00751.x

Martin, J., & Sugarman, J. (2001). Interpreting human kinds: Beginnings of a hermeneutic psychology. *Theory & Psychology*, *11*(2), 193-207. https://doi.org/10.1177/0959354301112003

Martinelli, T. F., Meerkerk, G. J., Nagelhout, G. E., Brouwers, E. P., van Weeghel, J., Rabbers, G., & van de Mheen, D. (2020). Language and stigmatization of individuals with mental health problems or substance addiction in the Netherlands: An experimental vignette study. *Health & social care in the community*, *28*(5), 1504-1513. https://doi.org/10.1111/hsc.12973

Maslow, A. H. (1958). A Dynamic Theory of Human Motivation. In C. L. Stacey & M. DeMartino (Eds.), *Understanding human motivation* (pp. 26–47). Howard Allen Publishers. https://doi.org/10.1037/11305-004

Maslow, A. H. (1966). Comments on Dr. Frankl's paper. *Journal of Humanistic Psychology*, *6*(2), 107-112. https://doi.org/10.1177/002216786600600202

Maslow, A. H. (1969). Various meanings of transcendence. *Journal of Transpersonal Psychology*, *1*(1), 56-66.

Mason, B. J. (2017). Emerging pharmacotherapies for alcohol use disorder. *Neuropharmacology*, *122*, 244-253. https://doi.org/10.1016/j.neuropharm.2017.04.032

Matthews, S. (2019). Self-stigma and addiction. In *The stigma of addiction: An essential guide* (pp. 5-32). Cham: Springer International Publishing. https://doi.org/10.1007/978-3-030-02580-9_2

Mawson, E., Best, D., Beckwith, M. Dingle, G.A., & Lubman, D.I. (2015). Social identity, social networks and recovery capital in emerging adulthood: A pilot study. *Substance abuse treatment prevention, and policy*, *10*, 1-11 . https://doi.org/10.1186/s13011-015-0041-2

McClure, P. K., & Wilkinson, L. R. (2020). Attending substance abuse groups and identifying as spiritual but not religious. *Review of Religious Research*, *62*(2), 197-218. https://doi.org/10.1007/s13644-020-00405-2

McCormack, R. P., Hoffman, L. F., Norman, M., Goldfrank, L. R., & Norman, E. M. (2015). Voices of homeless alcoholics who frequent Bellevue Hospital: a qualitative study. *Annals of emergency medicine*, *65*(2), 178-186. https://doi.org/10.1016/j.annemergmed.2014.05.025

McCrady, B. S., & Flanagan, J. C. (2021). The role of the family in alcohol use disorder recovery for adults. *Alcohol research: current reviews*, *41*(1). https://doi.org/10.35946/arcr.v41.1.06

McEwen, B. S. (2013). Allostasis and allostatic load: implications for neuropsychopharmacology. *Neuropsychopharmacology 2000*, *22*(2), 108-124. https://doi.org/10.1016/S0893-133X(99)00129-3

McGue, M., Iacono, W. G., Legrand, L. N., Malone, S., & Elkins, I. (2001). Origins and consequences of age at first drink. I. Associations with substance-use disorders, disinhibitory behavior and psychopathology, and P3 amplitude. *Alcoholism: clinical and experimental research*, *25*(8), 1156-1165. https://doi.org/10.1111/j.1530-0277.2001.tb02330.x

McEwen, B. S., & Akil, H. (2020). Revisiting the stress concept: implications for affective disorders. *Journal of Neuroscience*, *40*(1), 12-21. https://doi.org/10.1523/JNEUROSCI.0733-19.2019

McInerney, K., Best, D., & Cross, A. (2023). Characteristics of people who have received treatment for late-onset problem drinking and alcohol use disorder: A systematic review and narrative synthesis. *Nordic Studies on Alcohol and Drugs*, (Online First). https://doi.org/10.1177/14550725221143170

McInerney, K., Best, D., & Hodgson, P. (2024). A Cross-Sectional Study Investigating the Role of Meaning and Purpose in Life Among Older Individuals (≥ 50-Years Old) in Recovery from Alcohol Use Disorder/Problem Drinking. *Alcoholism Treatment Quarterly*, 1-23. https://doi.org/10.1080/07347324.2024.2423672

McInerney, K., & Cross, A. (2021): A Phenomenological Study: Exploring the Meaning of Spirituality in Long-term Recovery in Alcoholics Anonymous. *Alcoholism Treatment Quarterly*, *39*(3), 282-300. https://doi.org/10.1080/07347324.2021.1895016

McInerney, K., Garip, G., & Benson, T. (2021). “We all need Purpose and Reason to be here.”: A Qualitative Investigation of how members of Alcoholics Anonymous with Long-term Recovery Experience Aging. *Alcoholism Treatment Quarterly*, 1-16. https://doi.org/10.1080/07347324.2021.1947165

McKay, J. R., Lynch, K. G., Shepard, D. S., & Pettinati, H. M. (2005). The effectiveness of telephone-based continuing care for alcohol and cocaine dependence: 24-month outcomes. *Archives of general psychiatry*, *62*(2), 199-207. https://doi.org/10.1001/archpsyc.62.2.199

McKay, J. R., Van Horn, D., Oslin, D. W., Ivey, M., Drapkin, M. L., Coviello, D. M., ... & Lynch, K. G. (2011). Extended telephone-based continuing care for alcohol dependence: 24-month outcomes and subgroup analyses. *Addiction*, *106*(10), 1760-1769. https://doi.org/10.1111/j.1360-0443.2011.03483.x

McLaren, N., Jones, C. M., Noonan, R., Idaikkadar, N., & Sumner, S. A. (2023). Trends in stigmatizing language about addiction: a longitudinal analysis of multiple public communication channels. *Drug and alcohol dependence*, *245*, 109807. https://doi.org/10.1016/j.drugalcdep.2023.109807

Medina, M. (2014). The paradox of self-surrender and self-empowerment: An investigation of the individual’s understanding of the higher power in Alcoholics Anonymous. Counselling Psychology Review, 29(3), 28–42.

Meier, A., & Edwards, H. (1974). Purpose-in-Life Test: Age and sex differences. *Journal of Clinical Psychology*. https://doi.org/10.1002/1097-4679

Meier, P., & Seitz, H. K. (2008). Age, alcohol metabolism and liver disease. *Current Opinion in Clinical Nutrition & Metabolic Care*, *11*(1), 21-26. https://doi.org/10.1097/MCO.0b013e3282f30564

Melton, A. M., & Schulenberg, S. E. (2008). On the measurement of meaning: Logotherapy's empirical contributions to humanistic psychology. *The Humanistic Psychologist*, *36*(1), 31-44. https://doi.org/10.1080/08873260701828870

Mental Health Foundation. (2022, February 16). *Alcohol and mental health*. *Mental Health Foundation*. https://www.mentalhealth.org.uk/explore-mental-health/a-z-topics/alcohol-and-mental-health

Merleau-Ponty, M. (2013). *Phenomenology of perception*. Routledge.

Midanik, L. (1982). The validity of self-reported alcohol consumption and alcohol problems: a literature review. *British journal of addiction*, *77*(4), 357-382. https://doi.org/10.1111/j.1360-0443.1982.tb02469.x

Milani, R. M., Keller, A., & Roush, S. (2021). Dual diagnosis anonymous (DDA) and the transition to online support during COVID-19. *Journal of Concurrent Disorders*, *3*(3). https://doi.org/10.54127/jtfj8349

Milani, R. M., Nahar, K., Ware, D., Butler, A., Roush, S., Smith, D., ... & O'Donnell, J. (2020). A qualitative longitudinal study of the first UK Dual Diagnosis Anonymous (DDA), an integrated peer-support programme for concurrent disorders. *Advances in Dual Diagnosis*, *13*(4), 151-167. https://doi.org/10.1108/ADD-01-2020-0001

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with suicidal adolescents*. Guilford Press.

Mitchell, B. A., & Lovegreen, L. D. (2009). The empty nest syndrome in midlife families: A multimethod exploration of parental gender differences and cultural dynamics. *Journal of family issues*, *30*(12), 1651-1670. https://doi.org/10.1177/0192513X09339020

Mitchell, V., & Helson, R. M. (2016). The place of purpose in life in women's positive aging. *Women & Therapy*, *39*(1-2), 213-234. https://doi.org/10.1080/02703149.2016.1116856

Moadel, A., Morgan, C., Fatone, A., Grennan, J., Carter, J., Laruffa, G., ... & Dutcher, J. (1999). Seeking meaning and hope: self-reported spiritual and existential needs among an ethnically-diverse cancer patient population. *Psycho-Oncology: Journal of the Psychological, Social and Behavioral Dimensions of Cancer*, *8*(5), 378-385. https://doi.org/10.1002/(SICI)1099-1611

Moher D, Liberati A, Tetzlaff J, Altman DG; PRISMA Group. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. PLoS Med. 2009;6(7):e1000097. https://doi.org/1-.1371/journal.pmed.1000097

Molenberghs, P. (2013). The neuroscience of in-group bias. *Neuroscience & Biobehavioral Reviews*, *37*(8), 1530-1536. https://doi.org/10.1016/j.neubiorev.2013.06.002

Momper, S. L., Dennis, M. K., & Mueller-Williams, A. C. (2017). American Indian elders share personal stories of alcohol use with younger tribal members. *Journal of ethnicity in substance abuse*, *16*(3), 293-313. https://doi.org/10.1080/15332640.2016.1196633

Monk, G. E., Winslade, J. E., Crocket, K. E., & Epston, D. E. (1997). *Narrative therapy in practice: The archaeology of hope*. Jossey-Bass. https://doi.org/10.1002/casp.609

Moorhead, H. H. (1958). Study of alcoholism with onset forty-five years or older. *Bulletin of the New York Academy of Medicine*, *34*(2), 99-108.

Moos, R. H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. *Drug and alcohol dependence*, *88*(2-3), 109-121. https://doi.org/10.1016/j.drugalcdep.2006.10.010

Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2006). Older adults' coping with negative life events: Common processes of managing health, interpersonal, and financial/work stressors. *The International Journal of Aging and Human*

Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2005). Older adults' health and changes in late-life drinking patterns. *Aging & Mental Health*, *9*(1), 49-59 https://doi.org/10.1080/13607860412331323818

Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2010). Older adults' health and late-life drinking patterns: A 20-year perspective. *Aging and mental health*, *14*(1), 33-43. https://doi.org/10.1080/13607860902918264

Moos, R. H., Finney, J. W., & Cronkite, R. C. (1990). *Alcoholism treatment: Context, process, and outcome.* Oxford University Press.

Moos, R. H., & Moos, B. S. (2007). Protective resources and long-term recovery from alcohol use disorders. *Drug and alcohol dependence*, *86*(1), 46-54. https://doi.org/10.1016/j.drugalcdep.2006.04.015

Moos, R. H., & Moos, B. S. (2006). Rates and predictors of relapse after natural and treated remission from alcohol use disorders. *Addiction*, *101*(2), 212-222. http://dx.doi.org/10.1111/j.1360-0443.2006.01310.x

Moos, R. H., Schutte, K. K., Brennan, P. L., & Moos, B. S. (2009). Older adults' alcohol consumption and late-life drinking problems: a 20-year perspective. *Addiction*, *104*(8), 1293-1302. https://doi.org/10.1111/j.1360-0443.2009.02604.x

Morjaria, A., & Orford, J. (2002). The role of religion and spirituality in recovery from drink problems: a qualitative study of Alcoholics Anonymous members and South Asian men. *Addiction Research & Theory*, *10*(3), 225-256. https://doi.org/10.1080/16066350211864

Morris, J., Cox, S., Moss, A. C., & Reavey, P. (2023). Drinkers like us? The availability of relatable drinking reduction narratives for people with alcohol use disorders. *Addiction Research & Theory*, *31*(1), 1-8. https://doi.org/10.1080/16066359.2022.2099544

Morris, J., Moss, A. C., Albery, I. P., & Heather, N. (2022). The "alcoholic other": Harmful drinkers resist problem recognition to manage identity threat. *Addictive behaviors*, *124*, 107093. https://doi.org/10.1016/j.addbeh.2021.107093

Moss, J. (2014). Right reason in Plato and Aristotle: On the meaning of logos. *Phronesis, 59*(3), 181-230. https://doi.org/10.1163/15685284-12341266

Mowbray, O., Krentzman, A. R., Bradley, J. C., Cranford, J. A., Robinson, E. A. ., & Grogan-Kaylor, A. (2013). The effect of drinking goals at treatment entry on longitudinal alcohol use patterns among adults with alcohol dependence. *Drug and Alcohol Dependence*, *132*(1), 182–188. https://doi.org/10.1016/j.drugalcdep.2013.01.018

Mowbray, O., Washington, T., Purser, G., & O'Shields, J. (2017). Problem Drinking and Depression in Older Adults with Multiple Chronic Health Conditions. *Journal of the American Geriatrics Society (JAGS)*, *65*(1), 146–152. https://doi.org/10.1111/jgs.14479

Mulford, H. A. (1977). Stages in the alcoholic process. Toward a cumulative, nonsequential index. *Journal of Studies on Alcohol*, *38*(3), 563-583. https://doi.org/10.15288/jsa.1977.38.563

Mulford, H. A., & Fitzgerald, J. L. (1992). Elderly versus younger problem drinker profiles: do they indicate a need for special programs for the elderly?. *Journal of studies on alcohol*, *53*(6), 601-610. https://doi.org/10.15288/jsa.1992.53.601

Munn, Z., Tufanaru, C., & Aromataris, E. (2014). JBI's systematic reviews: data extraction and synthesis. *AJN The American Journal of Nursing*, *114*(7), 49-54. https://doi.org/10.1097/01.NAJ.0000451683.66447.89

Murakami, K. (2021). Learning in retirement: Developing resilience and becoming a resourceful practitioner of life. *Learning, Culture and Social Interaction*, *28*, 100463. https://doi.org/10.1016/j.lcsi.2020.100463

Musich, S., Wang, S. S., Kraemer, S., Hawkins, K., & Wicker, E. (2018). Purpose in life and positive health outcomes among older adults. *Population Health Management*, *21*(2), 139-147. https://doi.org 10.1089/pop.2017.0063

Nalin, C. P., & França, L. H. D. F. P. (2015). The Importance of Resilience for Well-Being in Retirement1. *Paidéia (Ribeirão Preto)*, *25*, 191-199. https://doi:10.1590/1982-43272561201507

National Institute for Health and Care Excellence. (2010, June 2). *Alcohol-use disorders: prevention. Guidance. Glossary*. NICE. https://www.nice.org.uk/guidance/ph24/chapter/Glossary#harmful-drinking-high-risk-drinking

National Institute for Health and Care Research. (2023, November 7). *Lived experience recovery organisations.* https://www.nihr.ac.uk/documents/lived-experience-recovery

NCADD. (2016). National Council on Alcoholism and Drug Dependence Inc. Research Update. *Alcoholics Anonymous and The Atlantic: A call for better science.* https://ncadd.us/blogs/research-update

Nelson, J., & Ogilvie, L. (2022). Addiction recovery stories: John Nelson in conversation with Lisa Ogilvie. *Advances in Dual Diagnosis*, *15*(2), 140–145. https://doi.org/10.1108/ADD-01-2022-0003

Nelson, L. A., Collins, S. E., Birch, J., Burns, R., McPhail, G., Onih, J., ... & Squetimkin-Anquoe, A. (2023). Content Analysis of Preferred Recovery Pathways Among Urban American Indians and Alaska Natives Experiencing Alcohol Use Disorders. *Journal of Cross-Cultural Psychology*, *54*(1), 142-160. https://doi.org/10.1177/00220221221132778

Neubauer, B. E., Witkop, C. T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on medical education*, *8*, 90-97. https://doi.org/10.1007/s40037-019-0509-2

NHS Digital. (2020, December 15). *Health Survey for England 2019 Adults' health-related behaviours*. https://files.digital.nhs.uk/D4/93337C/HSE19-Adult-health-behaviours-rep.pdf

NHS Digital. (2016, December 14). *Health Survey for England 2015. Adult alcohol consumption*. https://files.digital.nhs.uk/publicationimport/pub22xxx/pub22610/hse2015-adult-alc.pdf

Nicholson, D., McCormack, F., Seaman, P., Bell, K., Duffy, T., & Gilhooly, M. (2017). Alcohol and healthy ageing: a challenge for alcohol policy. *Public health*, *148*, 13-18. https://doi.org/10.1016/j.puhe.2017.02.021

Nicholson, T., Higgins, W., Turner, P., James, S., Stickle, F., & Pruitt, T. (1994). The relation between meaning in life and the occurrence of drug abuse: A retrospective study. *Psychology of Addictive Behaviors, 8*(1), 24–28. https://doi.org/10.1037/0893-164X.8.1.24

Nikolopoulou, K. (2022, November 16). Scribbr. *What Is Self-Selection Bias? Definition & Example*. https://www.scribbr.co.uk/bias-in-research/self-selection-bias-explained/

Noble, H., & Smith, J. (2018). Reviewing the literature: choosing a review design. https://doi.org/10.1136/eb-2018-102895

Noyes, E. T., Levine, J. A., Schlauch, R. C., Crane, C. A., Connors, G. J., Maisto, S. A., & Dearing, R. L. (2018). Impact of pretreatment change on mechanism of behavior change research: An applied example using alcohol abstinence self-efficacy. *Journal of studies on alcohol and drugs*, *79*(2), 223-228. https://doi.org/10.15288/jsad.2018.79.223

Oakes, K. E. (2008). Purpose in life: A mediating variable between involvement in Alcoholics Anonymous and long-term recovery. *Alcoholism Treatment Quarterly*, *26*(4), 450-463. https://doi.org/10.1080/07347320802347103

O'Connell, H., Chin, A. V., Cunningham, C., & Lawlor, B. (2003). Alcohol use disorders in elderly people–redefining an age old problem in old age. *Bmj*, *327*(7416), 664-667. https://doi.org/10.1136/bmj.327.7416.664

Office for Health Improvement & Disparities. (2021, November 25). *National Statistics. Adult substance misuse treatment statistics 2020-2021: report.* https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2020-to-2021/adult-substance-misuse-treatment-statistics-2020-to-2021-report#mental-health

Office for National Statistics. (2016, February 2). *Alcohol Related Deaths in the United Kingdom: registered in 2014*. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2014

Office for National Statistics. (2021a, February 2). *Alcohol-specific deaths in the UK: registered in 2019. Deaths caused by diseases known to be a direct consequence of alcohol-misuse by sex, age, region and deprivation.* https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2019

Office for National Statistics. (2021b, January 14). *Overview of the UK population: January 2021. An overview of the UK population in 2019 (before the coronavirus (COVID-19 pandemic): how it has changed, why it has changed and how it is projected to change in the future.* https://www.ons.gov.uk/peoplepopulationandcommunity/population

andmigration/populationestimates/articles/overviewoftheukpopulation/january2021#the-uks-population-continues-to-grow-but-at-a-slower-rate-than-previously

Office for National Statistics. (2020, June 24). *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2019*. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/latest

Ogborne, A.C. (1989). Some Limitations of Alcoholics Anonymous. In M. Galanter (Ed.), *Recent Developments in Alcoholism*, vol 7. Springer. https://doi.org/10.1007/978-1-4899-1678-5_3

O'Hare, T., & Shen, C. (2013). Abstinence self-efficacy in people with severe mental illness. *Journal of substance abuse treatment*, *45*(1), 76-82. https://doi.org/10.1016/j.jsat.2012.12.014

Okan, N., & Ekşi, H. (2017). Spirituality in logotherapy. *Spiritual Psychology and Counselling*, *2*(2), 143-164. https://doi.org/10.12738/spc.2017.2.0028

Orford, J., Velleman, R., Copello, A., Templeton, L., & Ibanga, A. (2010). The experiences of affected family members: A summary of two decades of qualitative research. *Drugs: education, prevention and policy*, *17*(sup1), 44-62. https://doi.org/10.3109/09687637.2010.514192

Osborn, M., & Smith, J. A. (1998). The personal experience of chronic benign lower back pain: An interpretative phenomenological analysis. *British Journal of Health Psychology*, *3*(1), 65-83. https://doi.org/10.1111/j.2044-8287.1998.tb00556.x

Oscar-Berman, M., Valmas, M. M., Sawyer, K. S., Ruiz, S. M., Luhar, R. B., & Gravitz, Z. R. (2014). Profiles of impaired, spared, and recovered neuropsychologic processes in alcoholism. *Handbook of clinical neurology*, *125*, 183-210. https://doi.org/10.1016/B978-0-444-62619-6.00012-4

Pakaluk, M. (2005). *Aristotle's Nicomachean ethics: An introduction*. Cambridge University Press.

Panel, T. B. F. I. C. (2007). What is recovery? A working definition from the Betty Ford Institute. *Journal of Substance Abuse Treatment*, *33*(3), 221-228. https://doi.org/10.1016/j.jsat.2007.06.001

Papaleontiou-Louca, E., Esmailinia, S., & Thoma, N. (2022). A critical review of Maslow's theory of spirituality. *Journal of Spirituality in Mental Health*, *24*(4), 327-343 https://doi.org/10.1080/19349637.2021.1932694

Parliament. House of Commons. (2023, May 18). *Alcohol treatment services. Fifty-Fourth Report od Session 2022-23*. https://committees.parliament.uk/publications/40045/documents/195525/default/

Peele, S. (1995). *Diseasing of America: How we allowed recovery zealots and the treatment industry to convince us we are out of control*. Prentice Hall.

Petit, G., Luminet, O., Maurage, F., Tecco, J., Lechantre, S., Ferauge, M., ... & de Timary, P. (2015). Emotion regulation in alcohol dependence. *Alcoholism: Clinical and Experimental Research*, *39*(12), 2471-2479. https://doi.org/10.1111/acer.12914

Pettersen, H., Landheim, A., Skeie, I., Biong, S., Brodahl, M., Oute, J., & Davidson, L. (2019). How Social Relationships Influence Substance Use Disorder Recovery: A Collaborative Narrative Study. *Substance Abuse : Research and Treatment*, *13*, 1178221819833379–1178221819833379. https://doi.org/10.1177/1178221819833379

Pettigrew, S., & Roberts, M. (2008). Addressing loneliness in later life. *Aging & Mental Health*, *12*(3), 302–309. https://doi.org/10.1080/13607860802121084

Phillips, E., Elander, J., & Montague, J. (2013). Managing multiple goals during fertility treatment: An interpretative phenomenological analysis. *Journal of Health Psychology*, *19*(4), 531-543. https://doi.org/10.1177/1359105312474915

Phillips, E., Elander, J., & Montague, J. (2014). An interpretative phenomenological analysis of men's and women's coping strategy selection during early IVF treatment. *Journal of Reproductive and Infant Psychology*. Advance online publication. https://doi.org/10.1080/02646838.2014.915391

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological journal*, *20*(1), 7-14. https://doi.org/10.14691/CPPJ.20.1.7

Pilling, J., Thege, B. K., Demetrovics, Z., & Kopp, M. S. (2012). Alcohol use in the first three years of bereavement: a national representative survey. *Substance abuse treatment, prevention, and policy*, *7*(1), 1-5.

Pitel, A. L., Beaunieux, H., Witkowski, T., Vabret, F., Guillery-Girard, B., Quinette, P., ... & Eustache, F. (2007). Genuine episodic memory deficits and executive dysfunctions in alcoholic subjects early in abstinence. *Alcoholism: Clinical and Experimental Research*, *31*(7), 1169-1178. https://doi.org/10.1111/j.1530-0277.2007.00418.x

Plant, M. (2005). Women and alcohol. In *Working with Substance Misusers* (pp. 276-284). Routledge.

Poole, R., Simpson, S. A., & Smith, D. J. (2012). Internet-based psychoeducation for bipolar disorder: a qualitative analysis of feasibility, acceptability and impact. *BMC Psychiatry*, *12*(1), 139–139. https://doi.org/10.1186/1471-244X-12-139

Pop, M. M. (2010). *Misunderstanding Addiction: Overcoming Myth, Mysticism, and Misdirection in the Addictions Treatment Industry*. iUniverse.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., ... & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*, b92. https://doi.org/10.13140/2.1.1018.4643

Pretorius, L., Naidoo, A. V., & Reddy, S. P. (2009). "Kitchen cupboard drinking": a review of South African women's secretive alcohol addiction, treatment history, and barriers to accessing treatment. *Social work in public health*, *24*(1-2), 89-99. https://doi.org/10.1080/19371910802569575

Price, C. A. (2003). Professional women's retirement adjustment: The experience of reestablishing order. *Journal of Aging Studies*, *17*(3), 341-355. https://doi.org/10.1016/S0890-4065(03)00026-4

Price, C. A. (2000). Women and retirement: Relinquishing professional identity. *Journal of aging Studies*, *14*(1), 81-101. https://doi.org/10.1016/S0890-4065(00)80017-1

Progressive Economy Forum. (2023, March 3). *The Macroeconomics of Austerity*. https://progressiveeconomyforum.com/publications/the-macroeconomics-of-austerity/

Project MATCH Research Group. (1998). Matching alcoholism treatments to client heterogeneity: Project MATCH three-year drinking outcomes. *Alcoholism: clinical and experimental research*, *22*(6), 1300-1311. https://doi.org/10.1111/j.1530-0277.1998.tb03912.x

Public Health England. (2020, October 21). *Wider impacts of COVID-19 on health (WICH) monitoring tool*. https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/

Puchalski, C., Ferrell, B., Virani, R., Otis-Green, S., Baird, P., Bull, J., ... & Sulmasy, D. (2009). Improving the quality of spiritual care as a dimension of palliative care: the report of the Consensus Conference. *Journal of palliative medicine*, *12*(10), 885-904. https://doi.org/10.1089=jpm.2009.0142

Puchalski, C. M., Vitillo, R., Hull, S. K., & Reller, N. (2014). Improving the spiritual dimension of whole person care: reaching national and international consensus. *Journal of palliative medicine*, *17*(6), 642-656. https://doi.org/10.1089/jpm.2014.9427

Puddephatt, J., & Goodwin, L. (2019, November). *Alcohol and mental health – what do we know?* Alcohol Change UK. https://alcoholchange.org.uk/blog/2019/alcohol-and-mental-health-what-do-we-know

Pulopulos, M.M., & Kozusznik, M.W. (2018). The moderating role of meaning in life in the relationship between stress and diurnal cortisol. *Stress*, *21*(3), 203-210. https://doi.org/10.1080/10253890.2018.1429397

Rabe, M. (2003). Revisiting 'insiders' and 'outsiders' as social researchers. *African Sociological Review/Revue Africaine de Sociologie*, *7*(2), 149-161.

Radicic, J. S., & Rivardo, M. G. (2019). The relationships between meaning in life, spirituality, and depression. *North American Journal of Psychology*, *21*(3), 525–540.

Randolph, J. (2009). A guide to writing the dissertation literature review. *Practical Assessment, Research, and Evaluation*, *14*(1), 13. https://doi.org/10.7275/b0az-8t74

Rao, R. (2011). Older people and dual diagnosis – out of sight, but not out of mind. *Advances in Dual Diagnosis*, *4*(1). https://doi.org/10.1108/add.2011.54104aaa.001

Rao, R. (2021). Older people and substance misuse. *Textbook of Addiction Treatment: International Perspectives*, 1407-1422. https://doi.org/10.1007/978-3-030-36391-8_99

Rao, R. (2019). Risky drinking and dual diagnosis in older people under a UK community old age psychiatry service. *Advances in Dual Diagnosis*, *12*(4). https://doi.org/10.1108/ADD-05-2019-0004

Rao, R., Crome, I., Crome, P., & Iliffe, S. (2019). Substance misuse in later life: challenges for primary care: a review of policy and evidence. *Primary Health Care Research & Development*, *20*, e117. https://doi.org/10.1017/S1463423618000440

Rao, R., Mueller, C., & Broadbent, M. (2021). Risky alcohol consumption in older people before and during the COVID-19 pandemic in the United Kingdom. *Journal of Substance Use*, 1-6. https://doi.org/10.1080/14659891.2021.1916851

Rao, R., Crome, I. B., & Crome, P. (2016). Managing older people's alcohol misuse in primary care. *British Journal of General Practice*, *66*(642), 6-7. https://doi.org/10.3399/bjgp16X683041

Rayburn, R. L. (2015). "I'm not an alcoholic anymore": Getting and staying sober without meetings. *Addiction Research & Theory*, *23*(1), 60-70. https://doi.org/10.3109/16066359.2014.929117

Reader, I. (2012). Secularisation, RIP? Nonsense! The 'rush hour away from the gods' and the decline of religion in contemporary Japan. *Journal of Religion in Japan*, *1*(1), 7-36. https://doi.org/10.1163/221183412X628370

Reker, G. T., & Cousins, J. B. (1979). Factor structure, construct validity and reliability of the Seeking of Noetic Goals (SONG) and Purpose in Life (PIL) tests. *Journal of Clinical Psychology*, *35*(1), 85-91. https://doi.org/10.1002/1097-4679

Rhodes, S., Greene, N. R., & Naveh-Benjamin, M. (2019). Age-related differences in recall and recognition: A meta-analysis. *Psychonomic Bulletin & Review*, *26*, 1529-1547. https://doi.org/10.3758/s13423-019-01649-y

Roberts, K. A., & Wilson, R. W. (2002, May). ICT and the research process: Issues around the compatibility of technology with qualitative data analysis. In *Forum Qualitative Sozialforschung/Forum: Qualitative Social Research*, *3*(2). https://doi.org/10.17169/fqs-3.2.862

Robinson, E. A., Krentzman, A. R., Webb, J. R., & Brower, K. J. (2011). Six-month changes in spirituality and religiousness in alcoholics predict drinking outcomes at nine months. *Journal of studies on alcohol and drugs*, *72*(4), 660-668. https://doi.org/10.15288/jsad.2011.72.660

Roepke, A. M., Jayawickreme, E., & Riffle, O. M. (2013). Meaning and health: A systematic review. *Applied Research in Quality of Life*, *9*, 1055–1079. doi:10.1007/s11482-013-9288-9

Roos, C. R., Kirouac, M., Pearson, M. R., Fink, B. C., & Witkiewitz, K. (2015). Examining temptation to drink from an existential perspective: Associations among temptation, purpose in life, and drinking outcomes. *Psychology of Addictive Behaviors*, *29*(3), 716. http://doi.org/10.1037/adb0000063

Rosenzweig, A., Prigerson, H., Miller, M. D., & Reynolds, C. F. (1997). Bereavement and late-life depression: Grief and its complications in the elderly. *Annual review of medicine*, *48*(1), 421-428. https://doi.org/10.1146/annurev.med.48.1.421

Rosin, A. J., & Glatt, M. M. (1971). Alcohol excess in the elderly. *Quarterly Journal of Studies on Alcohol*, *32*(1), 53-59. https://doi.org/10.15288/qjsa.1971.32.053

Ross, S. (2005). Alcohol use disorders in the elderly. *Primary psychiatry*, *12*(1), 32-40.

Roth, J. D., & Best, D. (Eds.). (2013). *Addiction and Recovery in the UK*. Routledge.

Rothenberg, W. A., Hussong, A. M., & Chassin, L. (2017). Modeling Trajectories of Adolescent-Perceived Family Conflict: Effects of Marital Dissatisfaction and Parental Alcoholism. *Journal of Research on Adolescence*, *27*(1), 105–121. https://doi.org/10.1111/jora.12259

Royal College of Psychiatrists. (2018, March). Our invisible addicts (2nd edition, CR211 Mar 2018). https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr211.pdf?sfvrsn=820fe4bc_2

Rubio, G., Marín, M., Arias, F., López-Trabada, J. R., Iribarren, M., Alfonso, S., ... & de Fonseca, F. R. (2018). Inclusion of alcoholic associations into a public treatment programme for alcoholism improves outcomes during the treatment and continuing care period: a 6-year experience. *Alcohol and Alcoholism*, *53*(1), 78-88. https://doi.org/10.1093/alcalc/agx078

Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological inquiry*, *9*(1), 1-28. https://doi.org/10.1207/s15327965pli0901_1

Saad, M., De Medeiros, R., & Mosini, A. C. (2017). Are we ready for a true biopsychosocial–spiritual model? The many meanings of "spiritual". *Medicines*, *4*(4), 79. https://doi:10.3390/medicines4040079

Sacco, P., Unick, G. J., Zanjani, F., & Camlin, E. A. (2015). Hospital outcomes in major depression among older adults: differences by alcohol comorbidity. *Journal of dual diagnosis*, *11*(1), 83-92. https://doi.org/10.1080/15504263.2014.993295

Sartre, J. P., & Mairet, P. (1960). *Existentialism and humanism* (p. 28). London: Methuen.

Satre, D. D., Blow, F. C., Chi, F. W., & Weisner, C. (2007). Gender differences in seven-year alcohol and drug treatment outcomes among older adults. *American Journal on Addictions*, *16*(3), 216-221. https://doi.org/10.1080/10550490701375673

Satre, D. D., Mertens, J. R., Arean, P. A., & Weisner, C. (2004). Five-year alcohol and drug treatment outcomes of older adults versus middle-aged and younger adults in a managed care program. *Addiction*, *99*(10), 1286-1297. https://doi.org/10.1111/j.1360-0443.2004.00831.x

Sattar, S. P., Petty, F., & Burke, W. J. (2003). Diagnosis and treatment of alcohol dependence in older alcoholics. *Clinics in geriatric medicine*, *19*(4), 743-761. https://doi.org/10.1016/S0749-0690(3)00045-4

Sawyer, A., Coleman, L., Cooke, R., Hodgson, L., & Sherriff, N. (2018). Understanding conversations about alcohol between parents and their 15-17 year olds: a qualitative study. *BMC Public Health*, *18*(1), 631–631. https://doi.org/10.1186/s12889-018-5525-3

Sawer, F., Davis, P., & Gleeson, K. (2020). Is shame a barrier to sobriety? A narrative analysis of those in recovery. *Drugs: Education, Prevention and Policy*, *27*(1), 79-85. https://doi.org/10.1080/09687637.2019.1572071

Schaberg, W. H. (2019). *Writing the Big Book: The creation of AA*. Central Recovery Press.

Schiller, J., Simonsson, B., & Molarius, A. (2023). At-risk drinking, loneliness and self-reported diagnosed depression among older people, 70–84 years of age. *Aging & Mental Health*, *27*(5), 1037-1044. https://doi.org/10.1080/13607863.2022.2098919

Schlosser, R W., Koul, R., & Costello, J. (2007). Asking well-built questions for evidence-based practice in augmentative and alternative communication. *Journal of communication disorders*, *40*(3), 225-238. https://doi.org/10.1016/j.jcomdis.2006.06.008

Schmid, J., & Brown, S. (2008). Beyond "Happily ever after": Family recovery from alcohol problems. *Alcoholism Treatment Quarterly*, *26*(1-2), 31-58. https://doi.org/10.1300/J020v26n01_03

Schofield, M., & Forrester-Knauss, C. H. (2010). Surveys and questionnaires in health research. *Research methods in health: Foundations for evidence-based practice*, 213-236.

Schonfeld, L., & Dupree, L. W. (1991). Antecedents of drinking for early-and late-onset elderly alcohol abusers. *Journal of Studies on Alcohol*, *52*(6), 587-592. https://doi.org/10.15288/jsa.1991.52.587

Schonfeld, L., Dupree, L. W., & Merritt, S. (1987). Alcohol Abuse and the Elderly: Comparison of Early & Late-Life Onset [Paper presentation]. The Annual Convention of the American Psychological Association, New York.

Schuckit, M. A., & Miller, P. L. (1976). Alcoholism in elderly men: A survey of a general medical ward. *Annals of the New York Academy of Sciences*, *273*(1), 558-571. https://doi.org/10.1111/j.1749-6632.1976.tb52929.x

Schutte, K. K., Brennan, P. L., & Moos, R. H. (1998). Predicting the development of late-life late-onset drinking problems: a 7-year prospective study. *Alcoholism: Clinical and Experimental Research*, *22*(6), 1349-1358. https://doi.org/10.1111/j.1530-0277.1998.tb03918.x

Schutte, K. K., Brennan, P. L., & Moos, R. H. (1994). Remission of late-life drinking problems: A 4-year follow-up. *Alcoholism: Clinical and Experimental Research*, *18*(4), 835-844. https://doi.org/10.1111/j.1530-0277.1994.tb00048.x

Schutter, N., Holwerda, T. J., Comijs, H. C., Stek, M. L., Peen, J., & Dekker, J. J. (2022). Loneliness, social network size and mortality in older adults: a meta-analysis. *European journal of ageing*, *19*(4), 1057-1076. https://doi.org/10.1007/s10433-022-00740-z

Schwartz, C. E., & Sendor, R. M. (1999). Helping others helps oneself: response shift effects in peer support. Social Science & Medicine (1982), 48(11), 1563–1575. https://doi.org/10.1016/S0277-9536(99)00049-0

Seddon, J., Trevena, P., Wadd, S., Elliott, L., Dutton, M., McCann, M., & Willmott, S. (2021). Addressing the needs of older adults receiving alcohol treatment during the COVID-19 pandemic: a qualitative study. *Aging & Mental Health*, 1-6. https://doi.org/10.1080/13607863.2021.1910794

Senner, F., Kohshour, M. O., Abdalla, S., Papiol, S., & Schulze, T. G. (2021). The genetics of response to and side effects of Lithium treatment in bipolar disorder: Future research

perspectives. *Frontiers in Pharmacology*, *12*, 638882. https://doi.org/10.3389/fphar.2021.638882

Share, D., McCrady, B., & Epstein, E. (2004). Stage of change and decisional balance for women seeking alcohol treatment. Addictive Behaviors, *29*(3), 525–535. https://doi.org/10.1016/j.addbeh.2003.08.022

Shaw, C., & Palattiyil, G. (2008). Issues of alcohol misuse among older people: Attitudes and experiences of social work practitioners. *Practice*, *20*(3), 181-193. https://doi.org/10.1080/09503150802341418

Shinebourne, P., & Smith, J. A. (2009). Alcohol and the self: An interpretative phenomenological analysis of the experience of addiction and its impact on the sense of self and identity. Addiction Research & Theory, 17(2), 152–167. https://doi:10.1080/16066350802245650

Shinebourne, P., & Smith, J. A. (2011). 'It is just habitual': An interpretative phenomenological analysis of the experience of long-term recovery from addiction. International Journal of Mental Health and Addiction, 9(3), 282–295. https://doi:10.1007/s11469-010-9286-1

Sinha, R. (2022). Alcohol's Negative Emotional Side: The Role of Stress Neurobiology in Alcohol Use Disorder. *Alcohol research: current reviews*, *42*(1). https://doi.org/10.35946/arcr.v42.1.12

Sisson, R. W., & Azrin, N. H. (1986). Family-member involvement to initiate and promote treatment of problem drinkers. *Journal of Behavior Therapy and Experimental Psychiatry*, *17*(1), 15-21. https://doi.org/10.1016/0005-7916(86)90005-4

Skrzynski, C. J., & Creswell, K. G. (2021). A systematic review and meta-analysis on the association between solitary drinking and alcohol problems in adults. *Addiction*, *116*(9), 2289-2303. https://doi.org/10.1111/add.15355

Sliedrecht, W., Seesink, H. J., Vrijmoeth, C., de Waart, R., Wiers, R. W., Ostafin, B., Schaap-Jonker, H., Roozen, H., Witkiewitz, K., & Dom, G. (2022). Alcohol use disorder relapse factors: an exploratory investigation of craving, alcohol dependence severity, and meaning in life. *Addiction Research & Theory*, *30*(5), 351–359. https://doi.org/10.1080/16066359.2022.2040488

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology and health*, *11*(2), 261-271. https://doi.org/10.1080/08870449608400256

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review*, *5*(1), 9-27. https://doi.org/10.1080/17437199.2010.510659

Smith, J. A. (2019). Participants and researchers searching for meaning: Conceptual developments for interpretative phenomenological analysis. *Qualitative Research in Psychology*, *16*(2), 166-181. https://doi.org/10.1080/14780887.2018.1540648

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. Sage Publications Inc.

Smith, J. A., & Nizza, I. E. (2022). Essentials of Interpretive Phenomenological Analysis. American Psychological Association. https://doi.org/10.1037/0000259-005

Smith J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1, 39–54.

Söderlund, H., Grady, C. L., Easdon, C., & Tulving, E. (2007). Acute effects of alcohol on neural correlates of episodic memory encoding. *Neuroimage*, *35*(2), 928-939. https://doi.org/10.1016/j.neuroimage.2006.12.024

Song, M. S., Jo, J. M., & Won, S. D. (2018). The Influence of Purpose in Life on Alcohol Self-Regulation Failure Among Male Inpatients with Alcohol Use Disorder: the Mediation Effects of Self-Control and Abstinence Self-Efficacy. *International Journal of Mental Health and Addiction*, *16*(4), 965-974. https://doi.org/10.1007/s11469-017-9814-3

Sorocco, K. H., Carnes, N. C., Cohoon, A. J., Vincent, A. S., & Lovallo, W. R. (2015). Risk factors for alcoholism in the Oklahoma Family Health Patterns project: impact of early life adversity and family history on affect regulation and personality. *Drug and alcohol dependence*, *150*, 38-45. https://doi.org/10.1016/j.drugalcdep.2015.02.001

Sorocco, K. H., & Ferrell, S. W. (2006). Alcohol use among older adults. *The Journal of general psychology*, *133*(4), 453-467. https://doi.org/10.3200/GENP.133.4.453-467

Stasiewicz, P. R., Schlauch, R. C., Bradizza, C. M., Bole, C. W., & Coffey, S. F. (2013). Pretreatment changes in drinking: relationship to treatment outcomes. *Psychology of Addictive Behaviors*, *27*(4), 1159–1166. https://doi.org/10.1037/a0031368.

Steckler, A., McLeroy, K. R., Goodman, R. M., Bird, S. T., & McCormick, L. (1992). Toward integrating qualitative and quantitative methods: An introduction. *Health education quarterly*, *19*(1), 1-8. https://doi.org/10.1177/109019819201900101

Steffens, N. K., Jetten, J., Haslam, C., Cruwys, T., & Haslam, S. A. (2016). Multiple social identities enhance health post-retirement because they are a basis for giving social support. *Frontiers in psychology*, *7*, 1519. https://doi.org/10.3389/fpsyg.2016.01519

Steffen, V. (1997). Life stories and shared experience. *Social Science & Medicine*, *45*(1), 99-111. https://doi.org/10.1016/S0277-9536(96)00319-X

Steger, M. F. (2007). Structural validity of the life regard index. *Measurement and Evaluation in Counseling and Development*, *40*(2), 97-109. https://doi.org/10.1080/07481756.2007.11909808

Steger, M. F., Frazier, P., Oishi, S., & Kaler, M. (2006). The meaning in life questionnaire: Assessing the presence of and search for meaning in life. *Journal of counselling psychology*, *53*(1), 80. https://doi.org/10.1037/0022-0167.53.1.80

Steigerwald, F., & Stone, D. (1999). Cognitive restructuring and the 12-step program of Alcoholics Anonymous. *Journal of Substance Abuse Treatment*, *16*(4), 321-327. https://doi.org/10.1016/S0740-5472(98)00052-X

Stein, J. A., Zane, J. I., & Grella, C. E. (2012). Impact of abstinence self-efficacy and treatment services on physical health-related behaviors and problems among dually diagnosed patients. *Journal of Dual Diagnosis*, *8*(1), 64-73. https://doi.org/10.1080/15504263.2012.647470

Stelle, C. D., & Scott, J. P. (2007). Alcohol abuse by older family members: A family systems analysis of assessment and intervention. *Alcoholism Treatment Quarterly*, *25*(1-2), 43-63. https://doi.org/10.1300/J020v25n01_04

Steptoe, A., & Fancourt, D. (2019). Leading a meaningful life at older ages and its relationship with social engagement, prosperity, health, biology, and time use. *Proceedings of the National Academy of Sciences*, *116*(4), 1207-1212. https://doi.org/10.1073/pnas.1814723116

Stickel, F., Moreno, C., Hampe, J., & Morgan, M. Y. (2017). The genetics of alcohol dependence and alcohol-related liver disease. *Journal of hepatology*, *66*(1), 195-211. https://doi.org/10.1016/j.jhep.2106.08.011

Stockwell, T., Zhao, J., Chikritzhs, T., & Greenfield, T. K. (2008). What did you drink yesterday? Public health relevance of a recent recall method used in the 2004 Australian National Drug Strategy Household Survey. *Addiction*, *103*(6), 919-928. https://doi.org/10.1111/j.1360-0443.2008.02219.x

Stockwell, T., Zhao, J., & Macdonald, S. (2014). Who under-reports their alcohol consumption in telephone surveys and by how much? An application of the 'yesterday method' in a national Canadian substance use survey. *Addiction*, *109*(10), 1657-1666. https://doi.org/10.1111/add.12609

Stockwell, T., Zhao, J., Sherk, A., Rehm, J., Shield, K., & Naimi, T. (2018). Underestimation of alcohol consumption in cohort studies and implications for alcohol's contribution to the global burden of disease. *Addiction*, *113*(12), 2245-2249. https://doi.org/10.1111/add.14392

Straus, E., Norman, S. B., Haller, M., Southwick, S. M., Hamblen, J. L., & Pietrzak, R. H. (2019). Differences in protective factors among US Veterans with posttraumatic stress disorder, alcohol use disorder, and their comorbidity: results from the National Health and Resilience in Veterans Study. *Drug and alcohol dependence*, *194*, 6-12. https://doi.org/10.1016/j.drugalcdep.2018.09.011

Subhani, M., Talat, U., Knight, H., Morling, J. R., Jones, K. A., Aithal, G. P., ... & Rennick-Egglestone, S. (2022). Characteristics of alcohol recovery narratives: systematic review and narrative synthesis. *Plos one*, *17*(5), e0268034. https://doi.org/10.1371/journal.pone.0268034

Substance Abuse and Mental Health Services Administration. (2012, February). *Publications and digital products*. *SAMHSA's working definition of recovery.* https://store.samhsa.gov/product/samhsas-working-definition-recovery/pep12-recdef

Suire, J. G., & Bothwell, R. K. (2006). The psychosocial benefits of Alcoholics Anonymous. The American Journal on Addictions, 15(3), 252–255. doi:10.1080/10550490600626622

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The gerontologist*, *42*(suppl_3), 24-33. https://doi.org/10.1093/geront/42.suppl_3.24

Sun, F., Chiu, N., Yao, Y., Wu, M., Hung, C., Chen, C., Lee, Y., & Chiang, C. (2022). The effects of logotherapy on meaning in life, depression, hopelessness, and suicidal ideation, in patients with depression: An intervention study. *Perspectives in Psychiatric Care*, *58*(4), 1891–1899. https://doi.org/10.1111/ppc.13003

Sutin, D. A. R., Luchetti, M., Aschwanden, D., Stephan, Y., Sesker, A. A., & Terracciano, A. (2023). Sense of meaning and purpose in life and risk of incident dementia: New data and meta-analysis. *Archives of Gerontology and Geriatrics*, *105*, 104847–104847. https://doi.org/10.1016/j.archger.2022.104847

Suzuki, S., Mell, M. M., O'Malley, S. S., Krystal, J. H., Anticevic, A., & Kober, H. (2020). Regulation of craving and negative emotion in alcohol use disorder. *Biological psychiatry: cognitive neuroscience and neuroimaging*, *5*(2), 239-250. https://doi.org/10.1016/j.bpsc.2019.10.005

Swora, M. G. (2004). The rhetoric of transformation in the healing of alcoholism: The twelve steps of Alcoholics Anonymous. *Mental health, religion & culture*, *7*(3), 187-209. https://doi:10.1080/13674670310001602445

Tampi, R. R., Chhatlani, A., Ahmad, H., Balaram, K., Dey, J., Escobar, R., & Lingamchetty, T. (2019). Substance use disorders among older adults: A review of randomized controlled pharmacotherapy trials. *World Journal of Psychiatry*, *9*(5), 78. https://doi.org/10.5498/wjp.v9.i5.78

Tashakkori, A., & Creswell, J. W. (2007). The new era of mixed methods. *Journal of mixed methods research*, *1*(1), 3-7. https://doi.org/10.1177/2345678906293042

Taylor, C., Jones, K. A., & Dening, T. (2014). Detecting alcohol problems in older adults: can we do better?. *International Psychogeriatrics*, *26*(11), 1755-1766. https://doi.org/10.1017/S1041610214001641

Teddlie, C., & Yu, F. (2007). Mixed methods sampling: A typology with examples. *Journal of mixed methods research*, *1*(1), 77-100. https://doi.org/ 10.1177/2345678906292430

Teuscher, U. (2010). Change and persistence of personal identities after the transition to retirement. *The International Journal of Aging and Human Development*, *70*(1), 89-106. https://doi.org/10.2190/AG.70.1.d

Tew, J. (2013). Recovery capital: What enables a sustainable recovery from mental health difficulties?. *European Journal of Social Work*, *16*(3), 360-374. https://doi.org/10.1080/13691457.2012.687713

Theeke, L. A. (2009). Predictors of Loneliness in U.S. Adults Over Age Sixty-Five. *Archives of Psychiatric Nursing*, *23*(5), 387–396. https://doi.org/10.1016/j.apnu.2008.11.002

Thomas, S. E., Randall, P. K., Book, S. W., & Randall, C. L. (2008). A complex relationship between co-occurring social anxiety and alcohol use disorders: what effect does treating social anxiety

have on drinking?. *Alcoholism: Clinical and Experimental Research*, *32*(1), 77-84. https://doi.org/10.1111/j.1530-0277.2007.00546.x

Thompson, G. R. (2018). Addiction treatment through the lens of meaning: Observations on a program developed in a residential facility. *International Journal of Existential Positive Psychology*, *7*(2), 13.

Ticehurst, S. (1990). Alcohol and the elderly. *Australian & New Zealand Journal of Psychiatry*, *24*(2), 252-260. https://doi.org/10.3109/00048679009077690

Tracy, K., & Wallace, S. P. (2016). Benefits of peer support groups in the treatment of addiction. *Substance Abuse and Rehabilitation*, *7*, 143–154. https://doi.org/10.2147/SAR.S81535

Treloar Padovano, H., Levak, S., Vadhan, N. P., Kuerbis, A., & Morgenstern, J. (2022). The role of daily goal setting among individuals with alcohol use disorder. *Drug and Alcohol Dependence Reports*, *2*, 100036–. https://doi.org/10.1016/j.dadr.2022.100036

Tucker, J. A., & Witkiewitz, K. (2022). Historical and Contemporary Perspectives on Pathways to Recovery from Alcohol Use Disorder. In J.A. Tucker & K. Witkiewitz (Eds.), *Dynamic Pathways to Recovery from Alcohol Use Disorder: Meaning and Methods* (pp. 3-21). Cambridge University Press. https://books.google.co.uk/books?hl=en&lr=&id=BctVEAAAQBAJ&oi=fnd&pg=PR10&dq=Dynamic+Pathways+to+Recovery+from+Alcohol+Use+Disorder&ots

Turner, J. C. (1991). *Social influence*. Thomson Brooks/Cole Publishing Co.

UK Drug Policy Commission. (2012). *A Fresh Approach to Drugs: The Final Report*. UK Drug Policy Commission.

United Nations Office on Drugs and Crime (2008, September). *Treatnet: International Network of Drug Dependence Treatment and Rehabilitation Resource Centres. Drug Dependence Treatment: Sustained Recovery Management Good Practice.* https://www.unodc.org/docs/treatment/111SUSTAINED_RECOVERY_MANAGEMENT.pdf

Vaillant, G. E. (2009). *The natural history of alcoholism revisited*. Harvard University Press

van den Berg, J. F., Hermes, J. S., van den Brink, W., Blanken, P., Kist, N., & Kok, R. M. (2014). Physical and mental health and social functioning in older alcohol-dependent inpatients: The role of age of onset. *European Addiction Research*, *20*(5), 226-232. https://doi.org/10.1159/000357322

van Melick, M., McCartney, D., & Best, D. (2013). Ongoing Recovery Support and Peer Networks: A Preliminary Investigation of Recovery Peer Supporters and Their Peers. *Journal of Groups in Addiction & Recovery*, *8*(3), 185–199. https://doi.org/10.1080/1556035X.2013.785211

Van Montfoort-De Rave, K. F., De Weert-Van Oene, G. H., Beurmanjer, H., & Koekkoek, B. (2017). Late-Onset alcohol dependence: patient-reported problems. *Addiction Research & Theory*, *25*(2), 139-145. https:// doi.org/10.1080/16066359.2016.1233967

Van Swol, L. M., Chang, C. T., Kerr, B., & Moreno, M. (2020). Linguistic predictors of problematic drinking in alcohol-related Facebook posts. *Journal of health communication*, *25*(3), 214-222. https://doi.org/10.1080/10810730.2020.1731632

Viktor Frankl's Logotherapy (2011, August 21). *Logos*. Retrieved April 12, 2023, from https://meaningtherapy.wordpress.com/2011/08/21/logos

Villiers-Tuthill, A., Copley, A., McGee, H., & Morgan, K. (2016). The relationship of tobacco and alcohol use with ageing self-perceptions in older people in Ireland. *BMC public health*, *16*(1), 1-10. https://doi.org/10.1186/s12889-016-3158-y

Wadd, S., & Galvani, S. (2014). Working with older people with alcohol problems: insight from specialist substance misuse professionals and their service users. *Social work education*, *33*(5), 656-669. https://doi.org/10.1080/02615479.2014.919076

Wadd, S., Lapworth, K., Sullivan, M. P., Forrester, D., & Galvani, S. (2011). *Working with older drinkers*. University of Bedfordshire.

Wadd, S., & Papadopoulos, C. (2014). Drinking behaviour and alcohol-related harm amongst older adults: analysis of existing UK datasets. *BMC research notes*, *7*(1), 741. https://doi.org/10.1186/1756-0500-7-741

Wagstaff, C., Jeong, H., Nolan, M., Wilson, T., Tweedlie, J., Phillips, E., ... & Holland, F. (2014). The accordion and the deep bowl of spaghetti: Eight researchers' experiences of using IPA as a methodology. *The qualitative report*, *19*(24), 1-15.

Waisberg, J.L. and Porter, J.E. (1994), Purpose in life and outcome of treatment for alcohol dependence. British Journal of Clinical Psychology, 33: 49-63. https://doi.org/10.1111/j.2044-8260.1994.tb01093.x

Wakeman, S. E. (2019). The language of stigma and addiction. In J. D. Avery & J. J. Avery (Eds.), *The stigma of addiction* (pp. 71-80). Springer. https://doi.org/10.1007/978-3-030-02580-9

Walmsley, I. (2023). Recognising the recovering addict with Honneth: an intervention into the stigmatising language debate in the alcohol and other drugs field. *Drugs, Habits and Social Policy*, *24*(3), 220-231. https://doi.org/10.1108/DHS-05-2023-0019

Walters, G. D. (2002). Twelve reasons why we need to find alternatives to Alcoholics Anonymous. *Addictive Disorders & Their Treatment*, *1*(2), 53-59. https://doi.org/10.1097/01.ADT.0000021102.21564.1B

Ward, B. M., & Snow, P. C. (2011). Factors affecting parental supply of alcohol to underage adolescents. *Drug and Alcohol Review*, *30*(4), 338–343. https://doi.org/10.1111/j.1465-3362.2010.00228.x

Ward, L., Barnes, M., & Gahagan, B. (2008). Cheers!? A project about older people and alcohol. *Health and Social Policy Research Centre, University of Brighton*.

Warren, J. I., Stein, J. A., & Grella, C. E. (2007). Role of social support and self-efficacy in treatment outcomes among clients with co-occurring disorders. *Drug and alcohol dependence*, *89*(2-3), 267-274. https://doi.org/10.1016/j.drugalcdep.2007.01.009

Watson, J., Toner, P., Day, E., Back, D., Brady, L. M., Fairhurst, C., ... & Copello, A. (2017). Youth social behaviour and network therapy (Y-SBNT): adaptation of a family and social network intervention for young people who misuse alcohol and drugs-a randomised controlled feasibility trial. *Health Technology Assessment*, *21*(15), 1. https://doi.org/10.3310/hta21150

Weegmann, M., & Piwowoz-Hjort, E. (2009). 'Naught but a story': Narratives of successful AA recovery. *Health Sociology Review*, *18*(3), 273-283. https://doi.org/10.5172/hesr.2009.18.3.273

Weir, M. C., Grimshaw, J. M., Mayhew, A., & Fergusson, D. (2012). Decisions about lumping vs. splitting of the scope of systematic reviews of complex interventions are not well justified: a case study in systematic reviews of health care professional reminders. *Journal of clinical epidemiology*, *65*(7), 756-763. https://doi.org/10.1016/j.jclinepi.2011.12.012

Wetterling, T., Veltrup, C., John, U., & Driessen, M. (2003). Late onset alcoholism. *European Psychiatry*, *18*(3), 112-118. https://doi.org/10.1016/S0924-9338(03)00025-7

Whipple, C. R., Jason, L. A., & Robinson, W. L. (2016). Housing and abstinence self-efficacy in formerly incarcerated individuals. *Journal of Offender Rehabilitation*, *55*(8), 548-563. https://doi.org/10.1080/10509674.2016.1229713

White, A. M. (2003). What happened? Alcohol, memory blackouts, and the brain. *Alcohol Research & Health*, *27*(2), 186.

White, M., & Epston, D. (1990). Narrative means to therapeutic ends. New York: Norton.

White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of substance abuse treatment*, *33*(3), 229-241. https://doi.org/10.1016/j.jsat.2007.04.015

White, W. L. (2004). Addiction recovery mutual aid groups: an enduring international phenomenon. *Addiction (Abingdon, England)*, *99*(5), 532–538. https://doi.org/10.1111/j.1360-0443.2004.00684.x

White, W. L. (2009). Peer-based Addiction Recovery Support. *History, Theory, Practice, and Scientific Evaluation*.

White, W. L. (2000). The history of recovered people as wounded healers: I. From Native America to the rise of the modern alcoholism movement. *Alcoholism treatment quarterly*, *18*(1), 1-23. https://doi.org/10.1300/J020v18n01_01

White W. L. (2001). The rhetoric of recovery advocacy: An essay on the power of language. In: *Let's go make some history: Chronicles of the new addictive recovery advocacy movement*, p. 37–76.

White, W. L., & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor*, *9*(5), 22-27. Available at www.williamwhitepapers.com

White, W. L., Kelly, J. F., & Roth, J. D. (2012). New Addiction-Recovery Support Institutions: Mobilizing Support Beyond Professional Addiction Treatment and Recovery Mutual Aid. *Journal of Groups in Addiction & Recovery*, *7*(2-4), 297–317. https://doi.org/10.1080/1556035X.2012.705719

White, W. L., & Kurtz, E. (2008). Twelve defining moments in the history of Alcoholics Anonymous. *Recent Developments in Alcoholism: Research on Alcoholics Anonymous and Spirituality in Addiction Recovery*, 37-57. https://doi.org/10.1007/978-0-387-77725-2_3

White, W.L., Laudet, A.B. & Becker, J.B. (2006). Life meaning and purpose in addiction recovery. *Addiction Professional*, *4*(4), 18-23. Posted at www.williamwhitepapers.com

White, W., & Savage, B. (2005). All in the family: Alcohol and other drug problems, recovery, advocacy. *Alcoholism Treatment Quarterly*, *23*(4), 3-37. https://doi.org/10.1300/J020v23n04_02

Widner, S., & Zeichner, A. (1991). Alcohol abuse in the elderly: Review of epidemiology research and treatment. *Clinical gerontologist*, *11*(1), 3-18. https://doi.org/10.1300/J018v11n01_02

Williams, I. L. (2021). An Apologetic Interpretation of Alcoholics Anonymous (AA): Timeless Wisdom, Outdated Language. *Substance Use & Misuse*, *56*(8), 1079-1094. https://doi.org/10.1080/10826084.2021.1892134

Willig, C. (2013). Introducing Qualitative Research in Psychology. Maidenhead: Open University Press.

Wilson, H. (2020). How stigmatising language affects people in Australia who use tobacco, alcohol and other drugs. *Australian Journal of General Practice*, *49*(3), 155-158. https://doi.org/10.31128/AJGP-07-19-4998

Wilson, W. G. (1967). *As Bill Sees it: The AA Way of Life--Selected Writings of AA's Co-founder*. Alcoholics Anonymous World Services.

Winzelberg, A., & Humphreys, K. (1999). Should patients' religiosity influence clinicians' referral to 12-step self-help groups? Evidence from a study of 3,018 male substance abuse patients. *Journal of Consulting and Clinical Psychology*, *67*(5), 790. https://doi.org/10.1037/0022-006X.67.5.790

Witkiewitz, K., Montes, K. S., Schwebel, F. J., & Tucker, J. A. (2020). What is recovery?. *Alcohol Research: Current Reviews*, *40*(3). https://doi.org/10.359

Witkiewitz, K., & Tucker, J. A. (2020). Abstinence not required: Expanding the definition of recovery from alcohol use disorder. *Alcoholism, clinical and experimental research*, *44*(1), 36. https://doi.org/10.1111/acer.14235.

Witkiewitz, K., & Villarroel, N. A. (2009). Dynamic association between negative affect and alcohol lapses following alcohol treatment. *Journal of consulting and clinical psychology*, *77*(4), 633. https://doi.org/10.1037/a0015647

Witkiewitz, K., Wilson, A. D., Roos, C. R., Swan, J. E., Votaw, V. R., Stein, E. R., ... & Tucker, J. A. (2021). Can individuals with alcohol use disorder sustain non-abstinent recovery? Non-Abstinent outcomes 10 years after alcohol use disorder treatment. *Journal of addiction medicine*, *15*(4), 303. https://doi.org/10.1097/ADM.0000000000000760

Wnuk, M. (2021). Indirect relationship between Alcoholics Anonymous spirituality and their hopelessness: The role of meaning in life, hope, and abstinence duration. *Religions*, *12*(11), 934. https://doi.org/10.3390/rel12110934

Wnuk, M., Marcinkowski, J. T., & Fobair, P. (2012). The relationship of purpose in life and hope in shaping happiness among patients with cancer in Poland. *Journal of Psychosocial Oncology*, *30*(4), 461-483. https://doi.org/10.1080/07347332.2012.684988

Wong, P. T. (2013). From logotherapy to meaning-centered counseling and therapy. In P. T. Wong (Ed.), *The human quest for meaning: Theories, research, and applications* (2nd ed., pp. 619-647). Routledge.

Wong, P.T. (2014). Viktor Frankl's Meaning-Seeking Model and Positive Psychology. In: Batthyany, A., Russo-Netzer, P. (eds.) *Meaning in Positive and Existential Psychology*. Springer, New York, NY. https://doi.org/10.1007/978-1-4939-0308-5_10

Wood, S. A. (2007). Developmental issues in older drinkers' decisions: To drink or not to drink. *Alcoholism Treatment Quarterly*, *24*(4), 99-118. https://doi.org/10.1300/J020v24n04_07

World Health Organization (2015, September 15). Ageing and life-course. *World report on ageing and health 2015*. https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf

World Health Organization. (2019a). *Harmful use of alcohol, alcohol dependence and mental health conditions: a review of the evidence for their association and integrated treatment approaches.* https://movendi.ngo/wp-content/uploads/2019/11/WHO-Harmful-use-of-alcohol-ENG.pdf

World Health Organization. (2019b). *International Statistical Classification of Diseases and Related Health Problems* (11th ed.). https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/1580466198

World Health Organization. (2020, March 31). *International Standards for the Treatment of Drug Use Disorders. Revised Edition Incorporating Results of Field-Testing.* https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders.pdf

Yehuda, R., Spiegel, D., Southwick, S., Davis, L. L., Neylan, T. C., & Krystal, J. H. (2016). What I have changed my mind about and why. *European Journal of Psychotraumatology*, *7*(1), 1-9. https://doi.org/10.3402/ejpt.v7.33768

Zimberg, S. (1978). Diagnosis and treatment of the elderly alcoholic. *Alcoholism: Clinical and experimental research*, *2*(1), 27-30. https://doi.org/10.1111/j.1530-0277.1978.tb04689.x

Zerssen, D. (1976). Paranoid-Depressivitäts-Skala. *Manual*. Weinheim.

Zilioli, S., Slatcher, R. B., Ong, A. D., & Gruenewald, T. L. (2015). Purpose in life predicts allostatic load ten years later. *Journal of Psychosomatic Research*, *79*(5), 451-457. https://doi.org/10.1016/j.jpsychores.2015.09.013

Zulauf, C. A., Sprich, S. E., Safren, S. A., & Wilens, T. E. (2014). The complicated relationship between attention deficit/hyperactivity disorder and substance use disorders. Current psychiatry reports, 16(3), 1-11. https://doi.org/10.1007/s11920-013-0436-6

APPENDICES

Several of the appendices are compiled of multiple pages or multiple files or both, and therefore are too large to be inserted into this appendices section. Please use the link below to access these files:

Link to Supplementary Files

70 Papers Rejected at Primary Screening of 135 Papers

	Paper	**Reason for rejecting at this stage**
1	Aira, M., Hartikainen, S., & Sulkava, R. (2008). Drinking alcohol for medicinal purposes by people aged over 75: a community-based interview study. *Family practice*, *25*(6), 445-449. https://doi:10.1093/fampra/cmn065	**Generic older problem drinking**, aged over 75 years only.
2	Atkinson, R. M. (1994). Late onset problem drinking in older adults. *International Journal of Geriatric Psychiatry*, *9*(4), 321-326. https://doi.org/10.1002/gps.930090409	**Review** of late-onset problem drinking in older adults.
3	Blow, F. C. (2000). Treatment of older women with alcohol problems: Meeting the challenge for a special population. *Alcoholism: Clinical and Experimental Research*, *24*(8), 1257-1266. https://doi.org/10.1111/j.1530-0277.2000.tb02092.x	**Report** on health services and treatment available for older women.
4	Blow, F. C., Walton, M. A., Chermack, S. T., Mudd, S. A., & Brower, K. J. (2000). Older adult treatment outcome following elder-specific inpatient alcoholism treatment. *Journal of substance abuse treatment*, *19*(1), 67-75. https://doi.org/10.1016/S0740-5472(99)00101-4	**Generic older problem drinking**, outcomes of elderly specific treatment.
5	Bobo, J. K., Greek, A. A., Klepinger, D. H., & Herting, J. R. (2010). Alcohol use trajectories in two cohorts of US women aged 50 to 65 at baseline. *Journal of the American Geriatrics Society*, *58*(12), 2375-2380. https:// doi:10.1111/j.1532-5415.2010.03180.x.	**Generic older problem drinking** gender specific: women only.
6	Brennan, P. L., & Moos, R. H. (1990). Life stressors, social resources, and late-life problem drinking *Psychology and Aging*, *5*(4), 491. https://doi.org/10.1037/0882-7974.5.4.491	**Generic older problem drinking**, in the context of stressors and social resources.
7	Brennan, P. L., Moos, R. H., & Mertens, J. R. (1994). Personal and environmental risk factors as predictors of alcohol use, depression, and treatment-seeking: A longitudinal analysis of late-life problem drinkers. *Journal of Substance Abuse*, *6*(2), 191-208. https://doi.org/10.1016/S0899-3289(94)90217-8	**Generic older problem drinking**.
8	Brennan, P. L., Schutte, K. K., & Moos, R. H. (2010). Patterns and predictors of late-life drinking trajectories: a 10-year longitudinal study. *Psychology of Addictive Behaviors*, *24*(2), 254. https://doi.org/10.1037/a0018592	**Generic older problem drinking.**
9	Breslow, R. A., Faden, V. B., & Smothers, B. (2003). Alcohol consumption by elderly Americans. *Journal of studies on alcohol*, *64*(6), 884-892. https://doi.org/10.15288/jsa.2003.64.884	**Generic older problem drinking**, among older Americans.
10	Bright, S. J., & Williams, C. M. (2017). Development of Australia's first older adult-specific early intervention for alcohol-related harm: Feasibility and proof of concept. *Australasian journal on ageing*, *36*(1), 52-55. https://doi.org/10.1111/ajag.12366	**Report** on older problem drinking and intervention protocol, in Australia.
11	Caputo, F., Vignoli, T., Leggio, L., Addolorato, G., Zoli, G., & Bernardi, M. (2012). Alcohol use disorders in the elderly: a brief overview from epidemiology to treatment options. *Experimental gerontology*, *47*(6), 411-416. https://doi:10.1016/j.exger.2012.03.019.	**Generic older problem drinking**, AUD among older adults.

12	Choi, N. G., & DiNitto, D. M. (2011). Drinking, smoking, and psychological distress in middle and late life. *Aging & mental health*, *15*(6), 720-731. https://doi.org/10.1080/13607863.2010.551343	**Generic older problem drinking** and middle-age.
13	Culberson, J. (2006). Alcohol use in the elderly: Beyond the CAGE. *Geriatrics*, *61*(10), 23-27.	**Commentary/Article on older problem drinking**.
14	Dufour, MD, MPH, M., & Fuller, MD, MS, R. K. (1995). Alcohol in the elderly. *Annual Review of Medicine*, *46*(1), 123-132. https://doi.org/10.1146/annurev.med.46.1.123	**Commentary/Article on older problem drinking**.
15	Edgar, F., Nicholson, D., Duffy, T., Seaman, P., Bell, K., & Gilhooly, M. (2016). Alcohol use across retirement: a qualitative study into drinking in later life. *Glasgow: University of West Scotland*.	**Generic older problem drinking**, qualitative report on drinking in retirement.
16	Erdoğan, E., Vardar, E., Altun, G. D., & FIRAT, M. F. (2018). Assessment of regional cerebral blood flow in patients with early and late onset alcohol dependence: SPECT study. *Journal of Surgery and Medicine*, *2*(3), 257-261. https://doi.org:10.28982/josam.420428	**Late-onset but not older context.** Brain imaging study. Late-onset was >20 years old.
17	Graham, K., Clarke, D., Bois, C., Carver, V., Dolinki, L., Smythe, C., ... & Brett, P. (1996). Addictive behavior of older adults. Addictive behaviors, 21(3), 331-348. https://doi.org/10.1016/0306-4603(95)00065-8	**Generic older problem drinking**, not late-onset.
18	Graham, K., Zeidman, A., Flowers, M. C., Saunders, S. J., & White-Campbell, M. (1993). A typology of elderly persons with alcohol problems. *Alcoholism Treatment Quarterly*, *9*(3-4), 79-95. https://doi.org/10.1300/J020v09n03_05	**(Generic) Typologies of older problem drinking,** not late-onset.
19	Haighton, C., Kidd, J., O'Donnell, A., Wilson, G., McCabe, K., & Ling, J. (2018). 'I take my tablets with the whiskey': A qualitative study of alcohol and medication use in mid to later life. *plos one*, *13*(10), e0205956. https://doi.org/10.1371/journal.pone.0205956	**(Generic) Alcohol and medication in an older population**. Not late-onset.
20	Herring, R., & Thom, B. (1997). The right to take risks: alcohol and older people. *Social policy & administration*, *31*(3), 233-246. https://doi.org/10.1111/1467-9515.00053	**Generic older problem drinking**.
21	Holahan, C. J., Schutte, K. K., Brennan, P. L., Holahan, C. K., & Moos, R. H. (2014). Episodic heavy drinking and 20-year total mortality among late-life moderate drinkers. *Alcoholism: Clinical and Experimental Research*, *38*(5), 1432-1438. https://doi.org/10.1111/acer.12381	**Generic older problem drinking**.
22	Huhn, A. S., Hobelmann, J. G., Ramirez, A., Strain, E. C., & Oyler, G. A. (2019). Trends in first-time treatment admissions for older adults with alcohol use disorder: Availability of medical and specialty clinical services in hospital, residential, and outpatient facilities. *Drug and alcohol dependence*, *205*, 107694 https://doi.org/10.1016/j.drugalcdep.2019.107694	**Generic older problem drinking**. Speciality treatment availability for older adults with AUD.
23	Hunter, I. R., & Gillen, M. C. (2006). Alcohol as a response to stress in older adults: A counseling perspective. *Adultspan Journal*, *5*(2), 114-126. https://doi.org/10.1002/j.2161-0029.2006.tb00022.x	**Commentary/Article on older problem drinking** and stress in the context of counselling.
24	Javors, M., Tiouririne, M., & Prihoda, T. (2000). Platelet serotonin uptake is higher in early-onset than in late-onset alcoholics. *Alcohol and Alcoholism*, *35*(4), 390-393. https://doi.org/10.1093/alcalc/35.4.390	**Late-onset but not older context**. Late-onset was >25 years old.

25	Kauppila, E., & Hellman, M. (2018). The role of alcohol in baby boomers' biographical accounts. *Journal of aging studies*, *46*, 37-44. https://doi.org/10.1016/j.jaging.2018.06.005	**Generic older problem drinking**.
26	Keyes, K. M., Calvo, E., Ornstein, K. A., Rutherford, C., Fox, M. P., Staudinger, U. M., & Fried, L. P. (2019). Alcohol consumption in later life and mortality in the United States: results from 9 waves of the health and retirement study. *Alcoholism: clinical and experimental research*, *43*(8), 1734-1746. 9 https://doi.org/10.1111/acer.14125	**Generic older problem drinking**.
27	Klausen, S. H., Engelsen, S., Christiansen, R., & Emiliussen, J. (2020). Elderly Well-Being and Alcohol: A Tricky Cocktail. *International Journal of Qualitative Methods*, *19*, 1-8. https://doi.org/10.1177/1609406920931687	**Study Protocol**.
28	Klein, W. C., & Jess, C. (2002). One last pleasure? Alcohol use among elderly people in nursing homes. *Health & Social Work*, *27*(3), 193-203. https://doi.org/10.1093/hsw/27.3.193	**Generic older problem drinking**.
29	Koenig, T. L., & Crisp, C. (2008). Ethical issues in practice with older women who misuse substances. *Substance use & misuse*, *43*(8-9), 1045-1061. https://10.1080/10826080801914246	**Generic older drinking and gender specific: women only**, and other substances.
30	Koivula, R., Tigerstedt, C., Vilkko, A., Kuussaari, K., & Pajala, S. (2016). How does older people's drinking appear in the daily work of home care professionals? *Nordic Studies on Alcohol and Drugs*, *33*(5-6), 537-550. https://doi.org/10.1515/nsad-2016-0044	**Generic older problem drinking**. Qualitative interviews with care-home professionals.
31	Kranzler, H. R., Pierucci-Lagha, A., Feinn, R., & Hernandez-Avila, C. (2003). Effects of ondansetron in early- versus late-onset alcoholics: a prospective, open-label study. *Alcoholism: Clinical and Experimental Research*, *27*(7), 1150-1155. https://doi.org/10.1097/01.ALC.0000075547.77464.76	**Late-onset but not older context.** Brain imaging study. Late-onset was ≥25 years old.
32	Lay, K., King, L. J., & Rangel, J. (2008). Changing characteristics of drug use between two older adult cohorts: Small sample speculations on baby boomer trends to come. *Journal of Social Work Practice in the Addictions*, *8*(1), 116-126. https://doi.org/10.1080/15332560802112078	**Primarily late-life drug dependence rather than alcohol**.
33	Li, J., Wu, B., Tevik, K., Krokstad, S., & Helvik, A. S. (2019). Factors associated with elevated consumption of alcohol in older adults—comparison between China and Norway: the CLHLS and the HUNT Study. *BMJ open*, *9*(8), e028646. http://dx.doi.org/10.1136/bmjopen-2018-028646	**Generic older problem drinking**.
34	Leggio, L., Kenna, G. A., Fenton, M., Bonenfant, E., & Swift, R. M. (2009). Typologies of alcohol dependence. From Jellinek to genetics and beyond. *Neuropsychology review*, *19*(1), 115-129.	**Review** of alcohol dependent subtypes.
35	LoCastro, J., Spiro III, A., Monnelly, E., & Ciraulo, D. (2000). Personality, family history, and alcohol use among older men: The VA Normative Aging Study. *Alcoholism: Clinical and Experimental Research*, *24*(4), 501-511. https://doi.org/10.1111/j.1530-0277.2000.tb02018.x	**Generic older problem drinking**, and other substances.
36	Mack, K. A. (2012). Revising the CAGE in Senior Alcoholism.	**Thesis, not peer-reviewed**.
37	Mayhugh, R. E., Moussa, M. N., Simpson, S. L., Lyday, R. G., Burdette, J. H., Porrino, L. J., & Laurienti, P. J. (2016). Moderate-heavy alcohol consumption lifestyle in older adults is associated with altered central executive network community structure during cognitive task. *PLoS One*, *11*(8), e0160214. https://doi.org/10.1371/journal.pone.0160214	**Generic older problem drinking**.

38	McEvoy, L. K., Kritz-Silverstein, D., Barrett-Connor, E., Bergstrom, J., & Laughlin, G. A. (2013). Changes in alcohol intake and their relationship with health status over a 24-year follow-up period in community-dwelling older adults. *Journal of the American Geriatrics Society*, *61*(8), 1303-1308. https://doi:10.1111/jgs.12366	**Generic older problem drinking**.
39	Mellor, M. J. (1996). Chapter VI: Alcohol and Aging. *Journal of Gerontological Social Work*, *25*(1-2), 71-90. https://doi.org/10.1300/J083V25N01_06	**Commentary/Article on older problem drinking** and ageing.
40	Mertens, J. R., Moos, R. H., & Brennan, P. L. (1996). Alcohol consumption, life context, and coping predict mortality among late-middle-aged drinkers and former drinkers. *Alcoholism: Clinical and Experimental Research*, *20*(2), 313-319. https://doi.org/10.1111/j.1530-0277.1996.tb01645.x	**Generic older problem drinking**. Middle-aged drinkers and former drinkers.
41	Mirand, A. L., & Welte, J. W. (1996). Alcohol consumption among the elderly in a general population, Erie County, New York. *American Journal of Public Health*, *86*(7), 978-984.	**Generic older problem drinking.** The effect of life-style on drinking.
42	Molander, R. C., Yonker, J. A., & Krahn, D. D. (2010). Age-related changes in drinking patterns from mid-to older age: results from the Wisconsin longitudinal study. *Alcoholism: Clinical and Experimental Research*, *34*(7), 1182-1192. https://doi.org/10.1111/j.1530-0277.2010.01195.x	**Generic older problem drinking**, not late-onset. Changes in drinking/predictors.
43	Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2004). High-risk alcohol consumption and late-life alcohol use problems. *American journal of public health*, *94*(11), 1985-1991. https://doi.org/10.2105/AJPH.94.11.1985	**Generic older problem drinking**.
44	Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2005). Older adults' health and changes in late-life drinking patterns. *Aging & Mental Health*, *9*(1), 49-59. https://doi.org/10.1080/13607860412331323818	**Generic older problem drinking**.
45	Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2010). Older adults' health and late-life drinking patterns: A 20-year perspective. *Aging and mental health*, *14*(1), 33-43. https://doi.org/10.1080/13607860902918264	**Generic older problem drinking**.
46	Moos, R. H., Schutte, K. K., Brennan, P. L., & Moos, B. S. (2010). Late-life and life history predictors of older adults' high-risk alcohol consumption and drinking problems. *Drug and alcohol dependence*, *108*(1-2), 13-20. https://doi.org/10.1016/j.drugalcdep.2009.11.005	**Generic older problem drinking**.
47	Mundt, M. P., French, M. T., Roebuck, M. C., Manwell, L. B., & Barry, K. L. (2005). Brief physician advice for problem drinking among older adults: an economic analysis of costs and benefits. *Journal of studies on alcohol*, *66*(3), 389-394. https://doi.org/10.15288/jsa.2005.66.389	**Generic older problem drinking**.
48	Nuevo, R., Chatterji, S., Verdes, E., Naidoo, N., Ayuso-Mateos, J. L., & Miret, M. (2015). Prevalence of alcohol consumption and pattern of use among the elderly in the WHO European region. *European addiction research*, *21*(2), 88-96. https://doi.org/10.1159/000360002	**Generic older problem drinking**.
49	Oliveira, C. D. B., de Almeida Deolino, S. M., Dutra, M. O. M., Ramos, A. P. A., Pereira, J. L. F., de Sousa, F. S., ... & de França, I. S. X. (2017). Abusive Consumption of Alcohol by Elderly. *International Archives of Medicine*, *10*. https://doi.org/10.3823/2395	**Generic older problem drinking**.

50	O'Sullivan, J. (2016). *Why do older adults develop problem drinking?: a qualitative study* (Doctoral dissertation, University of Surrey).	**Thesis, not peer-reviewed**.
51	Outlaw, F. H., Marquart, J. M., Roy, A., Luellen, J. K., Moran, M., Willis, A., & Doub, T. (2012). Treatment outcomes for older adults who abuse substances. *Journal of Applied Gerontology*, *31*(1), 78-100. https://doi.org/10.1177/0733464810382906	**Generic older problem drinking and substance abuse**.
52	Peterson, M., & Zimberg, S. (1996). Treating alcoholism: an age-specific intervention that works for older patients. *Geriatrics (Basel, Switzerland)*, *51*(10), 45-9.	**Generic older problem drinking**.
53	Rao, R., & Crome, I. (2016). Alcohol misuse in older people. *BJPsych Advances*, *22*(2), 118-126. https://doi.org/10.1192/apt.bp.115.014480	**Commentary/Article on older problem drinking**.
54	Rigler, S. K. (2000). Alcoholism in the elderly. *American Family Physician*, *61*(6), 1710-1716.	**Commentary/Article on older problem drinking**.
55	Sacco, P., Bucholz, K. K., & Harrington, D. (2014). Gender differences in stressful life events, social support, perceived stress, and alcohol use among older adults: results from a national survey. *Substance use & misuse*, *49*(4), 456-465. https://doi.org/10.3109/10826084.2013.846379	**Generic older problem drinking**. National Survey, gender differences.
56	Scafato, E. (2010). Alcohol and the elderly: the time to act is now! *European journal of public health*, *20*(6), 617-618. https://doi.org/10.1093/eurpub/ckq112	**Commentary/Article on older problem drinking**.
57	Sedlack, C. A., Doheny, M. O., Estok, P. J., & Zeller, R. A. (2000). Alcohol use in women 65 years of age and older. *Health care for women international*, *21*(7), 567-581. https://doi.org/10.1080/07399330050151824	**Generic older problem drinking** gender specific: women only.
58	Shaw, C., & Palattiyil, G. (2008). Issues of alcohol misuse among older people: Attitudes and experiences of social work practitioners. *Practice*, *20*(3), 181-193. https://doi.org/10.1080/09503150802341418	**Generic older problem drinking**.
59	Sher, K. J., Grekin, E. R., & Williams, N. A. (2005). The development of alcohol use disorders. *Annu. Rev. Clin. Psychol.*, *1*, 493-523. https://doi.org/10.1146/annurev.clinpsy.1.102803.144107	**Book Chapter on the development of AUD**
60	Sorocco, K. H., & Ferrell, S. W. (2006). Alcohol use among older adults. *The Journal of general psychology*, *133*(4), 453-467. https://doi.org/10.3200/GENP.133.4.453-467	**Commentary/Article on older problem drinking** and treatment.
61	Steunenberg, B., Yagmur, S., & Cuijpers, P. (2008). Depression and alcohol use among the Dutch residential home elderly: Is there a shared vulnerability?. *Addiction Research & Theory*, *16*(5), 514-525. https://doi.org/10.1080/16066350802041356	**Generic older problem drinking**.
62	St John, P. D., Snow, W. M., & Tyas, S. L. (2010). Alcohol use among older adults. *Reviews in Clinical Gerontology*, *20*(1), 56. https://doi.org/10.1017/S0959259810000031	**Commentary/Article on older problem drinking.**
63	Vergés, A., Jackson, K. M., Bucholz, K. K., Grant, J. D., Trull, T. J., Wood, P. K., & Sher, K. J. (2012). Deconstructing the age-prevalence curve of alcohol dependence: Why "maturing out" is only a small piece of the puzzle. *Journal of abnormal psychology*, *121*(2), 511. https://doi.org/10.1037/a0026027	**Not late-onset or later life context**.
64	Villiers-Tuthill, A., Copley, A., McGee, H., & Morgan, K. (2016). The relationship of tobacco and alcohol use with ageing self-perceptions in older people in Ireland. *BMC public health*, *16*(1), 1-10.	**Generic older problem drinking**.

65	Waldron, A., & McGrath, M. (2012). Alcohol disorders and older people: a preliminary exploration of healthcare professionals' knowledge, in Ireland. *International Journal of Therapy and Rehabilitation*, *19*(6), 352-358. https://doi.org/10.12968/ijtr.2012.19.6.352	**Generic older problem drinking**. Survey of healthcare professionals.
66	Ward, L., Barnes, M., & Gahagan, B. (2008). Cheers!? A project about older people and alcohol. *Health and Social Policy Research Centre, University of Brighton*.	**Generic older problem drinking**.
67	Widner, S., & Zeichner, A. (1991). Alcohol abuse in the elderly: Review of epidemiology research and treatment. *Clinical gerontologist*, *11*(1), 3-18. https://doi.org/10.1300/J018v11n01_02	**Commentary/Article on older problem drinking**.
68	Willenbring, M., & Spring, W. D. (1988). Evaluating alcohol use in elders. *Generations: Journal of the American Society on Aging*, *12*(4), 27-31. https://www.jstor.org/stable/44873140	**Commentary/Article** on screening older problem drinkers.
69	Wilsnack, R. W., & Cheloha, R. (1987). Women's roles and problem drinking across the lifespan. *Social Problems*, *34*(3), 231-248. https://doi.org/10.2307/800764	**Generic older problem drinking** gender specific: women only.
70	Wilson, G. B., Kaner, E. F., Crosland, A., Ling, J., McCabe, K., & Haighton, C. A. (2013). A qualitative study of alcohol, health and identities among UK adults in later life. *PloS one*, *8*(8), e71792. https://doi.org/10.1371/journal.pone.0071792	**Generic older problem drinking**, not late-onset.

	Categories of rejected papers	Number of papers
1	Generic older adult problem drinking (not late-onset specific)	43
2	Commentaries	11
3	Reviews	2
4	Reports	2
5	Late-onset but not older adult context (e.g., late-onset classified as problem drinking ≥25 years old)	3
6	Study Protocol	1
7	Generic older adult drinking and substance abuse	4
8	Thesis	2
9	Book Chapter on the development of AUD*	1
10	Not late-onset or later life context	1

**Included with generic older adult problem drinking in Prisma Flow Chart (Figure 1.)*

39 Papers Excluded at Final Screening of 65 Papers

	Paper	**Reason for rejecting at this stage**
1	Adams, S. L. (1990). *Late onset alcoholism in a midwestern setting: a matter of complexity* (Doctoral dissertation, The University of Nebraska-Lincoln).	**Adams' Doctoral Thesis, not peer reviewed**.
2	Atkinson, R. M. (1990). Aging and alcohol use disorders: Diagnostic issues in the elderly. *International Psychogeriatrics*, *2*(1), 55-72. https://doi.org/10.1017/S104161029000030	**Review.**
3	Bahr, H. M. (1969). Lifetime affiliation patterns of early-and late-onset heavy drinkers on Skid Row. *Quarterly journal of studies on alcohol*, *30*(3), 645-656. https://doi.org/10.15288/qjsa.1969.30.645	**Late-onset, but not older adults.**
4	Barrick, C., & Connors, G. J. (2002). Relapse prevention and maintaining abstinence in older adults with alcohol-use disorders. *Drugs & aging*, *19*(8), 583-594.	**Article/Commentary.**
5	Beresford, T. P., & Gordis, E. (1992). Alcoholism and the elderly patient. *Oxford Textbook of Geriatric Medicine. New York, NY: Oxford University Press Inc*, 639-646.	**Article/Commentary.**
6	Brennan, P. L., & Moos, R. H. (1996). Late-life drinking behavior: The influence of personal characteristics, life context, and treatment. *Alcohol Health and Research World*, *20*(3), 197.	**Late life, not necessarily late-onset**.
7	Brennan, P. L., & Moos, R. H. (1996). Late-life problem drinking: Personal and environmental risk factors for 4-year functioning outcomes and treatment seeking. *Journal of Substance Abuse*, *8*(2), 167-180. https://doi.org/10.1016/S0899-3289(96)90227-8	**Late life, not necessarily late-onset**.
8	Caputo, F., Vignoli, T., Leggio, L., Addolorato, G., Zoli, G., & Bernardi, M. (2012). Alcohol use disorders in the elderly: a brief overview from epidemiology to treatment options. *Experimental gerontology*, *47*(6), 411-416. https://doi.org/10.1016/jexger.2012.03.019	**Late life, not necessarily late-onset**.
9	Chen, Y. C., Prescott, C. A., Walsh, D., Patterson, D. G., Riley, B. P., Kendler, K. S., & Kuo, P. H. (2011). Different phenotypic and genotypic presentations in alcohol dependence: age at onset matters. *Journal of studies on alcohol and drugs*, *72*(5), 752-762. https://doi.org/10.15288/jsad.2011.72.752	**Late-onset, but not older adults**.
10	Cloninger, C. R., Bohman, M., & Sigvardsson, S. (1981). Inheritance of alcohol abuse: Cross-fostering analysis of adopted men. *Archives of general psychiatry*, *38*(8), 861-868. https://doi:10.1001/archpsyc.1981.01780330019001	**Late-onset, but not older adults**.
11	Das, A., Kar, S. K., Gupta, P. K., & Dalal, P. K. (2020). a Cross-sectional Study of Psychiatric Comorbidity and Severity of addiction in Patients with early-and late-Onset alcohol Dependence. *Indian Journal of Psychological Medicine*, *42*(4), 334-340. https://doi.org/10.1177/0253717620928443	**Late-onset, but not older adults**.
12	Demir, B., Uluğ, B. D., Ergün, E. L., & Erbaş, B. (2002). Regional cerebral blood flow and neuropsychological functioning in early and late onset alcoholism. *Psychiatry Research: Neuroimaging*, *115*(3), 115-125. https://doi.org/10.1016/S0925-4927(02)00071-9	**Late-onset, but not older adults**.
13	Dom, G., D'haene, P., Hulstijn, W., & Sabbe, B. G. C. C. (2006). Impulsivity in abstinent early-and late-onset alcoholics: differences in self-report measures and a discounting task. *Addiction*, *101*(1), 50-59. https://doi.org/10.1111/j.1360-0443.2005.01270.x	**Late-onset, but not older adults**.

14	Dom, G., Hulstijn, W., & Sabbe, B. G. C. C. (2006). Differences in impulsivity and sensation seeking between early-and late-onset alcoholics. *Addictive behaviors*, *31*(2), 298-308. https://doi.org/10.1016/j.addbeh.2005.05.009	**Late-onset, but not older adults**.
15	Dufour, MD, MPH, M., & Fuller, MD, MS, R. K. (1995). Alcohol in the elderly. Annual Review of Medicine, 46(1), 123-132. https://doi.org/10.1146/annurev.med.46.1.123	**Article/Review**.
16	Egbert, A. M. (1993). The older alcoholic: recognizing the subtle clinical clues. *Geriatrics (Basel, Switzerland)*, *48*(7), 63-6.	**Article/Commentary.**
17	Epstein, E. E., Fischer-Elber, K., & Al-Otaiba, Z. (2007). Women, aging, and alcohol use disorders. *Journal of women & aging*, *19*(1-2), 31-48. https://doi.org/10.1300/J074v19n01_03	**Article/Review**.
18	Giordano, J. A., & Beckham, K. (1985). Alcohol use and abuse in old age: an examination of type II alcoholism. *Journal of Gerontological Social Work*, *9*(1), 65-83. https://doi.org/10.1300/J083V09N01_06	**Review.**
19	Hauser, J., & Rybakowski, J. (1997). Three clusters of male alcoholics. *Drug and alcohol dependence*, *48*(3), 243-250. https://doi.org/10.1016/S0376-8716(97)00130-0	**Late-onset, but not older adults**.
20	Holahan, C. J., Schutte, K. K., Brennan, P. L., Holahan, C. K., Moos, B. S., & Moos, R. H. (2010). Late-life alcohol consumption and 20-year mortality. *Alcoholism: Clinical and Experimental Research*, *34*(11), 1961-1971. https://doi.org/10.1111/j.1530-0277.2010.01286.x	**Late life, not necessarily late-onset**.
21	Johnson, A. B., Cloninger, C. R., Roache, J. D., Bordnick, P. S., & Ruiz, P. (2000). Age of onset as a discriminator between alcoholic subtypes in a treatment-seeking outpatient population. *American Journal on Addictions*, *9*(1), 17-27. https://doi.org/10.1080/10550490050172191	**Late-onset, but not older adults**.
22	Joos, L., Schmaal, L., Goudriaan, A. E., Fransen, E., Van den Brink, W., Sabbe, B. G., & Dom, G. (2013). Age of onset and neuropsychological functioning in alcohol dependent inpatients. *Alcoholism: Clinical and Experimental Research*, *37*(3), 407-416. https://doi.org/10.1093/hsw/27.3.193	**Late-onset, but not older adults**.
23	Klein, W. C., & Jess, C. (2002). One last pleasure? Alcohol use among elderly people in nursing homes. *Health & Social Work*, *27*(3), 193-203.	**Late life, not necessarily late-onset**.
24	Lemke, S., & Moos, R. H. (2002). Prognosis of older patients in mixed-age alcoholism treatment programs. *Journal of Substance Abuse Treatment*, *22*(1), 33-43. https://doi.org/10.1016/S0740-5472(01)00209-4	**Late life, not necessarily late-onset**.
25	Maclean, F., Gill, J., O'May, F., & Breckenridge, J. (2015). Alcohol use amongst older adults: Knowledge and beliefs of occupational therapists working in physical health care settings. *British journal of occupational therapy*, *78*(5), 320-330. https://doi.org/10.1177/0308022614562790	**Late life, not necessarily late-onset**.
26	Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2004). High-risk alcohol consumption and late-life alcohol use problems. *American journal of public health*, *94*(11), 1985-1991. https://doi.org/10.2105/AJPH.94.11.1985	**Late life, not necessarily late-onset**.
27	Moos, R. H., Brennan, P. L., Schutte, K. K., & Moos, B. S. (2006). Older adults' coping with negative life events: common processes of managing health, interpersonal, and financial/work stressors. *The International Journal of Aging and Human Development*, *62*(1), 39-59. https://doi.org/10.2190/ENLH-WAA2-AX8J-WRT1 elderly	**Late life, not necessarily late-onset**.

28	Moos, R. H., Schutte, K. K., Brennan, P. L., & Moos, B. S. (2009). Older adults' alcohol consumption and late-life drinking problems: a 20-year perspective. *Addiction*, *104*(8), 1293-1302. https://doi.org/10.1111/j.1360-0443.2009.02604.x	**Late life, not necessarily late-onset**.
29	Moos, R. H., Schutte, K., Brennan, P., & Moos, B. S. (2004). Ten-year patterns of alcohol consumption and drinking problems among older women and men. *Addiction*, *99*(7), 829-838. https://doi.org/10.1111/j.1360-0443.2004.00760.x	**Late life, not necessarily late-onset**.
30	Myers, J. E., Dice, C. E., & Dew, B. J. (2000). Alcohol abuse in later life: Issues and interventions for counselors. *Adultspan Journal*, *2*(1), 2-14.	**Late life, not necessarily late-onset**.
31	Nelson, M.R. (1998). Alcohol Use in the Older Adult. *American Journal for Nurse Practitioners*, *2*(6), 24-32	**Review.**
32	Repo, E., Kuikka, J. T., Bergström, K. A., Karhu, J., Hiltunen, J., Tiihonen, J., & Kuikka, J. (1999). Dopamine transporter and D2-receptor density in late-onset alcoholism. *Psychopharmacology*, *147*(3), 314-318. https://doi.org/10.1007/s002130051173	**Late-onset, but not older adults**.
33	Ross, S. (2005). Alcohol use disorders in the elderly. *Primary psychiatry*, *12*(1), 32-40.	**Article/Commentary.**
34	Schonfeld, L., & Dupree, L. W. (1990). Older problem drinkers-long-term and late-life onset abusers: What triggers their drinking. *Aging*, *361*, 5-8.	**Article/Commentary.**
35	Schutte, K. K., Moos, R. H., & Brennan, P. L. (2006). Predictors of untreated remission from late-life drinking problems. *Journal of studies on alcohol*, *67*(3), 354-362. https://doi.org/10.15288/jsa.2006.67.354	**Late life, not necessarily late-onset**.
36	Simmill-Binning, C., Paylor, I., & Wilson, A. (2009). Alcohol and older people. *Drugs and Alcohol Today*. https://doi.org/10.1108/17459265200900014	**Review.**
37	Sorocco, K. H., & Ferrell, S. W. (2006). Alcohol use among older adults. *The Journal of general psychology*, *133*(4), 453-467. https://doi.org/10.3200/GENP.133.4.453-467	**Review.**
38	Varma, V. K., Basu, D., Malhotra, A., Sharma, A., & Mattoo, S. K. (1994). Correlates of early-and late-onset alcohol dependence. *Addictive behaviors*, *19*(6), 609-619. https://doi.org/10.1016/0306-4603(94)90016-7	**Late-onset, but not older adults**.
39	Widner, S., & Zeichner, A. (1991). Alcohol abuse in the elderly: review of epidemiology research and treatment. *Clinical gerontologist*, *11*(1), 3-18. https://doi.org/10.1300/J018v11n01_02	**Review.**

13 mentioned late-onset, but focus was on late-life problem drinking in older adults, not on late-onset.

12 did not report on late-onset in the context of.

13 articles, commentaries, reports, reviews.

1 thesis.

Record number	1		
Date of review	22 March 2021		
Study title	Comparisons of Purpose in Life Scores between Alcoholics with Early and later Onset		
Author/s	Adams and Waskel		
Year of publication	1991a	**Geography/culture**	USA
Journal	*Psychological Reports, 69*(3)		

Aims of study/phenomena of interest

To explore and determine whether 'meaning and purpose in life' was a stressor associated with the onset of problem drinking **and test the hypothesis that there may be a relationship between purpose in life and alcoholism in later life.** This was achieved by comparing the differences of Purpose in Life score between people with early-onset AUD (<40), Quasi-LO AUD between 40 and 60 years of age, and late-onset AUD (>60).

Participants/sample and setting

Sample size: $n = 60$, all male sample.

Age: ≥60, $m = 67.6$.

EO: $n = 30$. Drinking problems defined onset as before 40 years of age.

Quasi-LO: $n = 20$. Drinking problems defined onset as between 40 and 60 years of age.

LO: $n = 7$. Drinking problems defined as after 60 years of age.

For the purposes of this study, the Quasi-LO and LO were grouped together and referred to as LO. (total 27).

Data from three EO subjects could not be used

Thus, this study defined LO as >60.

Residential treatment centres setting.

Methodology

Quantitative, Cross-sectional study.

Method of data collection and analysis

Instruments used: VAST and Purpose in Life test. Purpose in Life test scores compared by statistical analysis (*t*-tests).

Results/key findings

PIL mean scores:

EO: 89.58 (*SD*=19.40). LO: 97.29 (*SD*=18.54). No significant differences between the two groups.

However, comparisons were also made between the groups and previously published Purpose in Life test scores:

The LO group in this study was compared with 2 groups from earlier studies:

1. An EO group of 38 men and women (Crumbaugh, 1968) AND
2. A group of 20 non-alcoholic, non-institutionalised older men (Meier, & Edwards, 1974).

Significant differences were found between these groups ($t = 2.50$, $p < .05$) and ($t = 2.51$, $p < .02$) respectively.

Treatments/interventions and follow-up (if any)

Although the men were in residential treatment, interventions were not described.

Authors' conclusions

The authors concluded that the significant differences found in comparisons with earlier groups could be because of secondary diagnosis. Additionally, another factor could be the differences in problematic drinking between the LO group in this (primary) study and the non-alcoholic, non-institutionalised men in one of the secondary studies.

Reviewer comments

All male sample

References

Crumbaugh, J. C. (1968). Cross-validation of purpose-in-life test based on Frankl's concepts. *Journal of individual psychology*, *24*(1), 74.

Meier, A., & Edwards, H. (1974). Purpose-in-Life Test: Age and sex differences. *Journal of Clinical Psychology*. https://doi.org/10.1002/1097-4679(197407)30:3<384::AID-JCLP2270300351>3.0.CO;2-

** Adapted from JBI QARI Data Extraction Tools:*

https://wiki.jbi.global/display/MANUAL/Appendix+2.3%3A+JBI+Qualitative+data+extraction+to

Data Extraction of the entire 26 papers are available by clicking the link below:

Link to Supplementary Files

Instruments used in the reviewed papers.

Instrument
Alcohol Stages Index (Mulford, 1977).
Beck Depression Inventory (Beck & Alford, 2009).
Brief Psychiatric Rating Scale (Overall & Gorham, 1962).
Composite International Diagnostic Interview (Robins et al., 1988).
Coping Responses Inventory (Moos et al., 1990a).
Depression Anxiety Stress Scales (Lovibond & Lovibond, 1996).
Drinking Practices Survey (Adams, 1990).
Drinking Problems Index (Finney et al., 1991).
The Drinking Profile (Marlatt, 1976).
Dutch Adult Reading Test (Schmand et al., 1991).
European version of the Addiction Severity Index (Europ-ASI; Kokkevi & Hartgers, 1995).
Form90 (Miller, 1996).
Gerontology Alcohol Project Drinking Profile (GAP-DP; Dupree & Schonfeld, 1986).
GAP Social Support Network Inventory (Dupree et al., 1984).
GAP Personal Stress Inventory (Dupree et al., 1984).
Health and Daily Living Form (Moos et al., 1990b).
Iowa Alcoholic Intake Schedule (Mulford, 1976).
International Classification of diseases 10th revision (WHO, 1992)
Inventory to Diagnose Depression — Lifetime Version (Zimmerman & Coryell, 1987).
Kaufman-Short Neuropsychological Assessment Procedure (Kaufman, 1994).
Life Satisfaction Inventory (Neugarten et al., 1961).
Life Stressors and Social Resources Inventory (Moos & Moos, 1988).
Locus of Control (I-E) Scale (Rotter, 1966).
MacAndrew MMPI scale: a scale derived from the Minnesota Multiphasic Personal Inventory (MacAndrew, 1981)
The Maudsley Addiction Profile (MAP; Marsden et al., 1998).
Measurements of the Addiction for Triage and Evaluation (MATE; Schippers et al., 2010).
Minnesota Multiphasic Personal Inventory (Butcher, 2010).
MINI International Neuropsychiatric Interview 5th Edition (Sheean, 1998).
Motivation: Importance, Confidence, Readiness Rulers Worksheet (Rollnick et al., 1997).
Obsessive Compulsive Drinking Scale (Anton et al., 1996).
Personal Adjustment and Roll Skills (PARS) Scales (Ellsworth, 1979).
Purpose in Life Test (Crumbaugh,1968; Crumbaugh & Maholick, 1964).
Research Diagnostic Criteria (Spitzer et al., 1978).
State-Trait Anxiety Inventory (Patterson et al., 1980).

Stokes-Gordon Stress Scale (Stokes & Gordon, 1988).
Stroop Colour Word Test (Stroop, 1935).
Thoughts about Alcohol Abstinence Questionnaire (Hall et al., 1991).
Thoughts about Alcohol Abstinence Scale (Emiliussen et al., 2019).
Trail Making Test (Tombaugh, 2004).
Wechsler Adult Intelligence Scale (Wechsler, 1955).
Veterans Alcoholism Screening Test (Magruder-Habib et al., 1982).

References

Adams, S. L. (1990). Late onset alcoholism in a midwestern setting: a matter of complexity. ETD *collection for University of Nebraska - Lincoln*. AAI9108205. https://digitalcommons.unl.edu/dissertations/AAI9108205

Anton, R. F., Moak, D. H., & Latham, P. K. (1996). The obsessive-compulsive drinking scale: A new method of assessing outcome in alcoholism treatment studies. *Archives of general psychiatry*, *53*(3), 225-231. https://doi.org/10.1001/archpsyc.1996.01830030047008

Beck, A. T., & Alford, B. A. (2009). *Depression: Causes and treatment*. University of Pennsylvania Press.

Butcher, J. N. (2010). Minnesota multiphasic personality inventory. *The Corsini Encyclopedia of Psychology*, 1-3. https://doi.org/10.1002/9780470479216.corpsy0573

Crumbaugh, J. C. (1968). Cross-validation of purpose-in-life test based on Frankl's concepts. *Journal of individual psychology*, *24*(1), 74.

Crumbaugh, J. C., & Maholick, L. T. (1964). An experimental study in existentialism: The psychometric approach to Frankl's concept of noogenic neurosis. *Journal of clinical psychology*, *20*(2), 200-207.

Dupree, L. W., & Schonfeld, L. (1986). Alcohol assessment and treatment planning for alcohol abusers: A curriculum manual. *FMHI Publication series*, (109).

Dupree, L. W., Broskowski, H., & Schonfeld, L. (1984). The Gerontology Alcohol Project: A behavioral treatment program for elderly alcohol abusers. *The Gerontologist*, *24*(5), 510-516. https://doi.org/10.1093/geront/24.5.510

Ellsworth. R.B. (1979). *Personal Adjustment and Role Skills (PARS Scales)*. Institute for Program Evaluation.

Emiliussen, J., Andersen, K., Nielsen, A. S., Braun, B., & Bilberg, R. (2019). What do elderly problem drinkers aim for? Choice of goal for treatment among elderly treatment-seeking alcohol-dependent patients. *Nordic Studies on Alcohol and Drugs*, *36*(6), 511-521.https://doi/10.1177/1455072519852852

Finney, J. W., Moos, R. H., & Brennan, P. L. (1991). The Drinking Problems Index: A measure to assess alcohol-related problems among older adults. *Journal of substance abuse*, *3*(4), 395-404. https://doi.org/10.1002/9780470479216.corpsy0573

Hall, S. M., Havassy, B. E., & Wasserman, D. A. (1991). Effects of commitment to abstinence, positive moods, stress, and coping on relapse to cocaine use. *Journal of consulting and clinical psychology*, *59*(4), 526. https://doi.org/10.1037/0022-006X.59.4.526

Kaufman, A. S. (1994). K-SNAP: Kaufman short neuropsychological assessment procedure. Circle Pines, MN: American Guidance Service.

Kokkevi, A., & Hartgers, C. (1995). EuropASI: European adaptation of a multidimensional assessment instrument for drug and alcohol dependence. *European addiction research*, *1*(4), 208-210. https://doi.org/10.1159/000259089

Lovibond, S. H., & Lovibond, P. F. (1996). *Manual for the depression anxiety stress scales*. Psychology Foundation of Australia.

MacAndrew, C. (1981). What the MAC scale tells us about men alcoholics. An interpretive review. *Journal of Studies on Alcohol*, *42*(7), 604-625. https://doi.org/10.15288/jsa.1981.42.604.

Magruder-Habib, K., Harris, K. E., & Fraker, G. G. (1982). Validation of the Veterans Alcoholism Screening Test. *Journal of Studies on Alcohol*, *43*(9), 910-926. https://doi.or/10.15288/jsa.1982.43.910

Marlatt, G. A. (1976). The drinking profile: A questionnaire for the behavioral assessment of alcoholism. *Behavior therapy assessment: Diagnosis, design, and evaluation*, 121-137.

Marsden, J., Gossop, M., Stewart, D., Best, D., Farrell, M., Lehmann, P., ... & Strang, J. (1998). The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome. *Addiction*, *93*(12), 1857-1867.

Miller, W. R. (1996). Form 90: A structured assessment interview for drinking and related behaviors: Test manual.

Moos, R. H., Brennan, P. L., Fondacaro, M. R., & Moos, B. S. (1990a). Approach and avoidance coping responses among older problem and nonproblem drinkers. *Psychology and aging*, *5*(1), 31. https://doi.org/10.1037/0882-7974.5.1.31

Moos, R. H., Cronkite, R. C., & Finney, J. W. (1990b). *Health and daily living form manual*. Center for Health Care Evaluation, Stanford University Medical Center.

Moos, R. H., & Moos, B. (1988). Life stressors and social resources inventory: Preliminary manual. *Palo Alto, CA: Stanford University Medical Center*.

Mulford, H. A. (1976). Iowa Alcoholic Intake Schedule Model 4. Alcohol Studies Division, University of Iowa College of Medicine.

Mulford, H. A. (1977). Stages in the alcoholic process. Toward a cumulative, nonsequential index. *Journal of Studies on Alcohol*, *38*(3), 563-583. https://doi.org/10.15288/jsa.1977.38.563

Neugarten, B. L., Havighurst, R. J., & Tobin, S. S. (1961). The measurement of life satisfaction. *Journal of gerontology*. https://doi.org/10.1093/geronj/16.2.134

Overall, J. E., & Gorham, D. R. (1962). The brief psychiatric rating scale. *Psychological reports*, *10*(3), 799-812. https://doi.org/10.2466/pr0.1962.10.3.799

Patterson, R. L., O'Sullivan, M. J., & Spielberger, C. D. (1980). Measurement of state and trait anxiety in elderly mental health clients. *Journal of Behavioral Assessment*, *2*(2), 89-97.

Robins, L. N., Wing, J., Wittchen, H. U., Helzer, J. E., Babor, T. F., Burke, J., ... & Sartorius, N. (1988). The Composite International Diagnostic Interview: an epidemiologic instrument suitable for use in conjunction with different diagnostic systems and in different cultures. *Archives of general psychiatry*, *45* (12), 1069-1077. https://doi.org/10.1001/archpsyc.1988.01800360017003

Rollnick, S., Butler, C. C., & Stott, N. (1997). Helping smokers make decisions: the enhancement of brief intervention for general medical practice. *Patient education and counseling*, *31*(3), 191-203. https://doi.org/10.1016/S0738-3991(97)01004-5

Rotter, J.B. (1966). Generalized expectancies for internal vs. external control of reinforcement. *Psychological Monographs*, *80*(1, Whole No. 609).

Schmand, B., Bakker, D., Saan, R., & Louman, J. (1991). The Dutch Reading Test for Adults: a measure of premorbid intelligence level. *Tijdschrift voor gerontologie en geriatrie*, *22*(1), 15-19.

Sheehan, D. V., Lecrubier, Y., Sheehan, K. H., Amorim, P., Janavs, J., Weiller, E., …Dunbar, G. C. (1998). The Mini-MINI International Neuropsychiatric Interview (M.I.N.I.): The development and validation of a structured diagnosis psychiatric interview for DCM-IV and ICD-10. *The Journal of Clinical Psychiatry*, *59*(Suppl. 20), 22-33, quiz 34-57.

Schippers, G. M., Broekman, T. G., Buchholz, A., Koeter, M. W., & Van Den Brink, W. (2010). Measurements in the Addictions for Triage and Evaluation (MATE): an instrument based on the World Health Organization family of international classifications. *Addiction*, *105*(5), 862-871. https://doi.org/10.1111/j.1360-0443.2009.02889.x

Spitzer, R. L., Endicott, J., & Robins, E. (1978). Research diagnostic criteria: rationale and reliability. *Archives of general psychiatry*, *35*(6), 773-782. https://doi.org/10.1001/archpsyc.1978.01770300115013

Stokes, S. A., & Gordon, S. E. (1988). Development of an instrument to measure stress in the older adult. *Nursing Research*, *37*(1), 16-19.

Stroop, J. R. (1935). Studies of interference in serial verbal reactions. *Journal of experimental psychology*, *18*(6), 643. https://doi.org/10.1037/h0054651

Tombaugh, T. N. (2004). Trail Making Test A and B: normative data stratified by age and education. *Archives of clinical neuropsychology*, *19*(2), 203-214. https://doi.org/10.1016/S0887-6177(03)00039-8

Wechsler, D. (1955). Manual for the Wechsler adult intelligence scale.

World Health Organization. (1992). International classification of diseases, 10th revision.

Zimmerman, M., & Coryell, W. (1987). The inventory to diagnose depression, lifetime version. *Acta Psychiatrica Scandinavica*, *75*(5), 495-499. https://doi.org/10.1111/j.1600-0447.1987.tb02824.x

CASP
Critical Appraisal Skills Programme

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CASP Checklist: 12 questions to help you make sense of a Cohort Study

How to use this appraisal tool: Three broad issues need to be considered when appraising a cohort study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 12 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Cohort Study) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

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Paper for appraisal and reference: 24 — Van Montfoort-De Rave et al., 2017

Section A: Are the results of the study valid?

1. Did the study address a clearly focused issue?

Yes ✔
Can't Tell
No

HINT: A question can be 'focused' in terms of
- the population studied
- the risk factors studied
- is it clear whether the study tried to detect a beneficial or harmful effect
- the outcomes considered

Comments:

2. Was the cohort recruited in an acceptable way?

Yes ✔
Can't Tell
No

HINT: Look for selection bias which might compromise the generalisability of the findings:
- was the cohort representative of a defined population
- was there something special about the cohort
- was everybody included who should have been

Comments:

Is it worth continuing?

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3. Was the exposure accurately measured to minimise bias?

Yes ✔
Can't Tell
No

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- were all the subjects classified into exposure groups using the same procedure

Comments:

4. Was the outcome accurately measured to minimise bias?

Yes ✔
Can't Tell
No

HINT: Look for measurement or classification bias:
- did they use subjective or objective measurements
- do the measurements truly reflect what you want them to (have they been validated)
- has a reliable system been established for detecting all the cases (for measuring disease occurrence)
- were the measurement methods similar in the different groups
- were the subjects and/or the outcome assessor blinded to exposure (does this matter)

Comments:

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5. (a) Have the authors identified all important confounding factors?

Yes ☐
Can't Tell ☑
No ☐

HINT:
- list the ones you think might be important, and ones the author missed

Comments:

5. (b) Have they taken account of the confounding factors in the design and/or analysis?

Yes ☑
Can't Tell ☐
No ☐

HINT:
- look for restriction in design, and techniques e.g. modelling, stratified-, regression-, or sensitivity analysis to correct, control or adjust for confounding factors

Comments:

6. (a) Was the follow up of subjects complete enough?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- the good or bad effects should have had long enough to reveal themselves
- the persons that are lost to follow-up may have different outcomes than those available for assessment
- in an open or dynamic cohort, was there anything special about the outcome of the people leaving, or the exposure of the people entering the cohort

6. (b) Was the follow up of subjects long enough?

Yes ☐
Can't Tell ☐
No ☐

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Comments:	

Section B: What are the results?

7. What are the results of this study?

HINT: Consider
- what are the bottom line results
- have they reported the rate or the proportion between the exposed/unexposed, the ratio/rate difference
- how strong is the association between exposure and outcome (RR)
- what is the absolute risk reduction (ARR)

Comments:	Comprehensive results (see p. 58 of Lit. Review Appendix 4, Data Extraction for details)

8. How precise are the results?

HINT:
- look for the range of the confidence intervals, if given

Comments:	(see p. 58 of Lit. Review Appendix 4, Data Extraction for details)

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9. Do you believe the results?

Yes	✔
Can't Tell	
No	

HINT: Consider
- big effect is hard to ignore
- can it be due to bias, chance or confounding
- are the design and methods of this study sufficiently flawed to make the results unreliable
- Bradford Hills criteria (e.g. time sequence, dose-response gradient, biological plausibility, consistency)

Comments:

Section C: Will the results help locally?

10. Can the results be applied to the local population?

Yes	✔
Can't Tell	
No	

HINT: Consider whether
- a cohort study was the appropriate method to answer this question
- the subjects covered in this study could be sufficiently different from your population to cause concern
- your local setting is likely to differ much from that of the study
- you can quantify the local benefits and harms

Comments:

11. Do the results of this study fit with other available evidence?

Yes	✔
Can't Tell	
No	

Comments:

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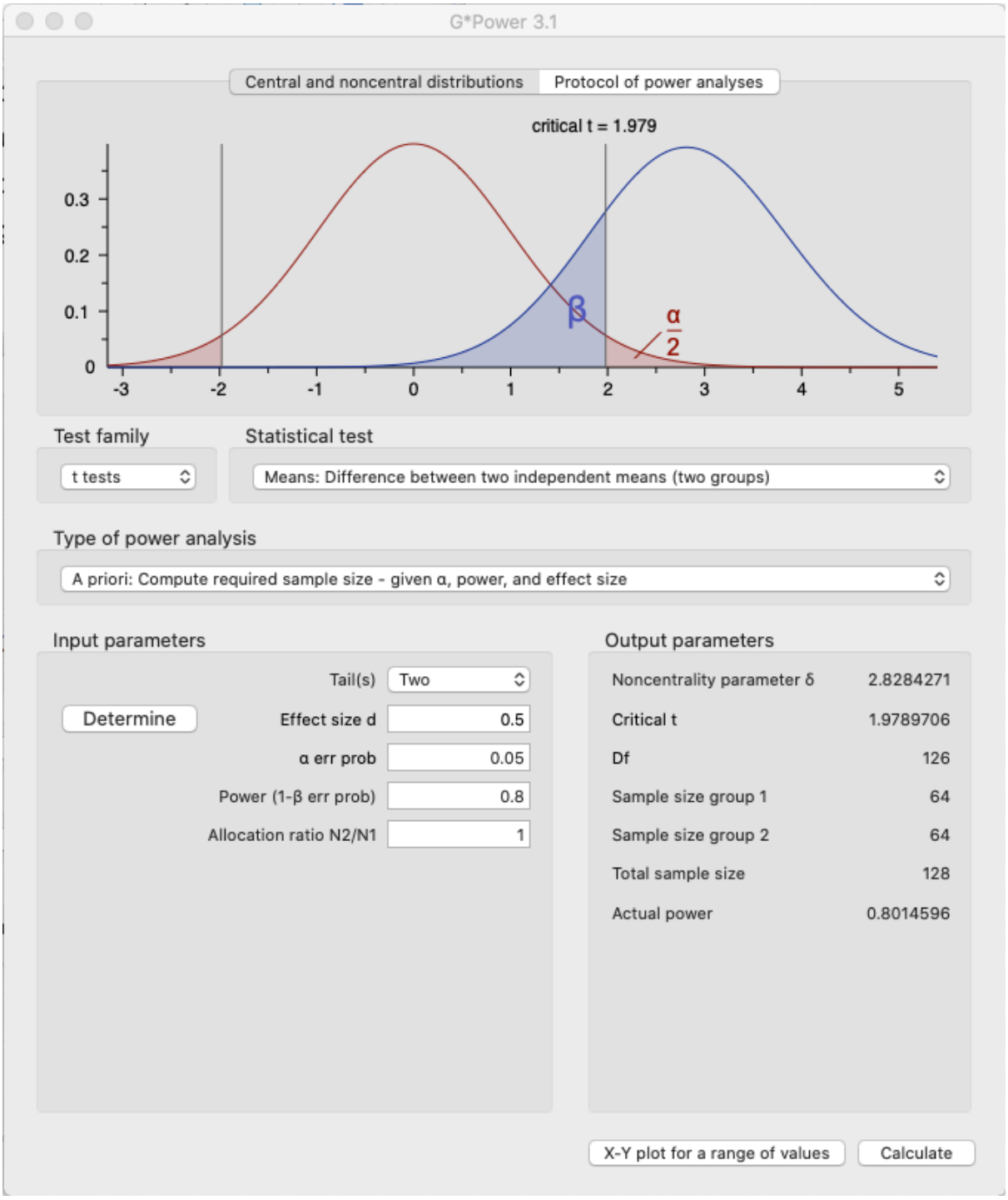
12. What are the implications of this study for practice?

Yes	✔
Can't Tell	
No	

HINT: Consider
- one observational study rarely provides sufficiently robust evidence to recommend changes to clinical practice or within health policy decision making
- for certain questions, observational studies provide the only evidence
- recommendations from observational studies are always stronger when supported by other evidence

Comments:	The authors suggest that treatment programmes may to be tailored, especially to meet the needs of this unique group, and that such programmes need to address the physical health problems of this ageing population and also promote meaningful daily activities.


G*Power 3.1
Central and noncentral distributions
Protocol of power analyses
critical t = 1.979
0.3
0.2
0.1
0
-3
-2
-1
0
1
2
3
4
5
β
α/2
Test family
t tests
Statistical test
Means: Difference between two independent means (two groups)
Type of power analysis
A priori: Compute required sample size - given α, power, and effect size
Input parameters
Tail(s) Two
Determine
Effect size d 0.5
α err prob 0.05
Power (1-β err prob) 0.8
Allocation ratio N2/N1 1
Output parameters
Noncentrality parameter δ 2.8284271
Critical t 1.9789706
Df 126
Sample size group 1 64
Sample size group 2 64
Total sample size 128
Actual power 0.8014596
X-Y plot for a range of values
Calculate

Interview schedule (to be piloted)

The purpose of my research is to understand why some people, who have used alcohol moderately (or not at all) for most of their life, start drinking problematically later in life (late-onset drinkers). To that end, I am interviewing both late- and early onset drinkers, with the aim of investigating the similarities and differences between the groups, in the context of their lived experiences of both active problematic drinking and recovery. If you feel uncomfortable about any of the interview questions, you do not have to answer them, and you can stop the interview at any time you wish. You can also go back and revisit questions. At the end of the interview, you will have the opportunity to ask questions and express any further thoughts. Are you happy to begin the interview?

1. At what age, roughly, did you begin to drink problematically, and why do you think that was? For instance, what difficulties were you experiencing in your life at the time? What had changed?
2. People who drank problematically often say they drank because it changed the way they felt. What did alcohol do for you? How did it make you feel?
3. It is quite natural that as we age, we are increasingly likely to experience major life-changing events. For example, this could be the loss of a loved one, retirement, long-term illness and pain, and other important and meaningful events. If you experienced any of these or any other major events, how did it affect your drinking? (*This question is particularly personal and sensitive, and depending on the answer, will require prompts to elicit a fuller conversation of the event (see prompts on page 2).*
4. When you were drinking heavily, what other problems did you experience?
5. How did your problematic drinking affect you psychologically and emotionally? *(This question may need specific prompts, see page 2).*
6. What made you begin to question your drinking? For example, was it a single event, or a culmination of events?
7. What was your experience of stopping drinking and coming into recovery? What difficulties did you experience? How hard was it for you?
8. How did your drinking affect your family relationships?
9. How were you encouraged and supported by family and/or friends to in your efforts to stop drinking? And now that you are in recovery, how supportive are they?
10. What meaning and purpose does your life have now that you are in recovery?
11. What, if any, are your religious or spiritual beliefs, and how important are they to you, in recovery and in life generally?
12. In closing, can you share any hopes and plans you have for the future?

Prompts for question 3:

- If subject is tentative about sharing, briefly share own experience of triggers:
- If talking about deceased spouse/partner/loved one:

  What impact did xxxx have on your life?

  What do you miss most about xxxxx?

  How did you meet?

  How long were you together?

- If talking about work pre- and post-retirement:

  How much do you miss work?

  What did work mean to you?

  How important were your relationships with your colleagues?

  How has retirement and not going to work affected your identity?

  How has not going to work affected financial security?

- If talking about pain:

  How long have you experienced chronic pain and what are your coping mechanisms?

General prompts to encourage the interviewee to respond in greater detail and depth:

- Prompt: *Can you expand on that a bit please?*
- Prompt: *How important is_____ in your life then?*
- Prompt: *What do you mean by that?*
- Prompt: *How important is that to you?*
- Prompt: *Can you elaborate on that?*
- Prompt: *In what way/s have you changed?*
- Prompt: *How does that make you feel?*
- Prompt: *In what ways was/is it different?*

Interview schedule (to be piloted)

The purpose of my research is to understand why some people, who have used alcohol moderately (or not at all) for most of their life, start drinking problematically later in life (late-onset drinkers). To that end, I am interviewing both late- and early onset drinkers, with the aim of investigating the similarities and differences between the groups, in the context of their lived experiences of both active problematic drinking and recovery. If you feel uncomfortable about any of the interview questions, you do not have to answer them, and you can stop the interview at any time you wish. You can also go back and revisit questions. At the end of the interview, you will have the opportunity to ask questions and express any further thoughts. Are you happy to begin the interview?

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2. People who drank problematically often say they drank because it changed the way they felt. What did alcohol do for you? How did it make you feel?
3. How did your problematic drinking affect you psychologically and emotionally? *(This question may need specific prompts, see page 2).*
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5. What made you begin to question your drinking? For example, was it a single event, or a culmination of events?
6. What was your experience of stopping drinking and coming into recovery? What difficulties did you experience? Was it hard for you?
7. How did your drinking affect your family relationships?
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10. What, if any, are your religious or spiritual beliefs, and how important are they to you, in recovery and in life generally?
11. In closing, can you share any hopes and plans you have for the future?

Closing remarks

- Is there anything else you would like to add before the interview finishes?
- Thank you for taking part in this study.

Prompts

- If subject is tentative about sharing, briefly share own experience of triggers:
- If talking about deceased spouse/partner/loved one:

  What impact did xxxx have on your life?

  What do you miss most about xxxxx?

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- Prompt: *How does that make you feel?*
- Prompt: *In what ways was/is it different?*

Prompts for question 4:

- *For example, did your life have meaning and a purpose to it? Was boredom and apathy a trigger to drink more?*

Interview schedule

The purpose of my research is to understand why some people, who have used alcohol moderately (or not at all) for most of their life, start drinking problematically later in life (late-onset drinkers). To that end, I am interviewing both late- and early onset drinkers, with the aim of investigating the similarities and differences between the groups, in the context of their lived experiences of both active problematic drinking and recovery. If you feel uncomfortable about any of the interview questions, you do not have to answer them, and you can stop the interview at any time you wish. You can also go back and revisit questions. At the end of the interview, you will have the opportunity to ask questions and express any further thoughts. Are you happy to begin the interview?

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9. What meaning and purpose does your life have now that you are in recovery?
10. How would you describe your spiritual beliefs, and how important are they to you?

Closing remarks

- Is there anything else you would like to add before the interview finishes?
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Prompts

- If subject is tentative about sharing, briefly share own experience of triggers:
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- Prompt: *How important is that to you?*
- Prompt: *Can you elaborate on that?*
- Prompt: *In what way/s have you changed?*
- Prompt: *How does that make you feel?*
- Prompt: *In what ways was/is it different?*

Prompts for question 4:

- *For example, did your life have meaning and a purpose to it? Was boredom and apathy a trigger to drink more?*

☐ **What is your age?**

Gender
☐ Female
☐ Male
☐ Other
☐ Prefer not to say

Sexual Identity
☐ Gay
☐ Straight
☐ Other
☐ Prefer not to say

Relationship status
☐ Married/cohabiting
☐ Divorced/separated
☐ Widowed
☐ Single

Employment Status
Employed full-time ☐ Employed part-time ☐ Not working ☐ Retired ☐

The age at which you perceived that your drinking became problematic? ☐

Times in residential treatment
☐ More than once
☐ Once
☐ Never

Current drinking status
☐ Abstinent
☐ Drinking

Years in recovery/length of sobriety ☐

Spirituality/Belief system *(Please indicate which of the following best applies to you?)*
☐ Religious
☐ Spiritual, i.e., your life philosophy is not based on a divine being/deity/God ☐ Secular

My name is Kevin McInerney,

I am undertaking a research degree (PhD) at the University of Derby (UK). My Director of Studies, David Best, a professor of criminology, is a leading expert/researcher in addiction and recovery. He was seconded on the UK governments Delivery Unit to work on a priority review of drug treatment effectiveness and is currently involved in addiction research projects in the UK, Belgium, Netherlands, Canada, the US, Australia, and New Zealand.

My research investigates the phenomenon of late-onset alcohol use disorder (AUD)/problem drinking in older adults (50+) a sub-group of older drinkers who constitute one-third of all older problem drinkers. This is an area of alcohol harm that has been overlooked and under-researched. The aim of the research is to contribute to a better understanding of late-onset problem drinking in older adults (50+) and inform and help health and social care professionals who regularly encounter older individuals.

I am contacting relevant organisations who may be sympathetic to my research, and who might consider directing suitable participants to a survey that forms a part of my research. I am myself an older person (70) with lived experience of addiction and 32 years of recovery. My research has received ethical approval from my university. Additionally, I am collaborating with my local NHS Trust — Surrey and Borders Partnership (SABP) — and the outcome of my NHS ethical application is imminent (the Research Ethics Committee meeting took place last week).

I have attached a participant information sheet, A4 poster (with QR code), and proof of my university's ethical approval. Please do contact me if further information is required. For your information, and to show you what is involved in the research at this stage, I have included a link to the survey (link below):

Late-onset Problem Drinking in Older Adults

By participating in this research, people will be contributing to an important and under-researched area of alcoholism and problem drinking.

Thank you

Kind regards
Kevin McInerney — MSc Health Psychology; BSc (Hons) Psych (Open); MBPsS

Main recovery-orientated organisations contacted.

Alcoholics Anonymous (Members of)

Build on Bob

Changes UK (Birmingham)

Club Soda

Double Impact (Nottingham)

Edinburgh Alcohol and Drugs Partnership

Faces & Voices of Recovery UK

Forward Trust

Humankind

Lothian Edinburgh Abstinence Programmed (LEAP) NHS Trust

Phoenix Futures

Priory Group

Smart Recovery

South London and Maudsley (SLAM) NHS Trust

Surrey and Borders Partnership (SABP) NHS Trust*

Surrey Drug and Alcohol Care Ltd.

Turning Point

Westminster Drug Project (WDP)

Additionally, a google search for alcohol/drug-orientated charities and community drug/alcohol services was undertaken, which revealed a plethora of suitable organisations, who were also contacted.

*Subsequent NHS ethical approval (*Appendix 3.10b*) relates to the SABP NHS trust, who were the only NHS Trust to respond.

Invitation to Participate in Psychological Research/Information Sheet

Research title: Late-onset Problem drinking in older people (50+): Psychosocial Characteristics and the Role of Meaning and Purpose in Life.

My name is Kevin McInerney, I am undertaking a research degree (PhD). Before deciding if you would like to participate, it is important that you understand the purpose of this research and what participation involves.

What are the objectives of the study?

The study investigates the psychological and social characteristics of older adults who begin drinking problematically later in life, referred to as 'late-onset'. Late-onset drinkers account for one-third of all older problem drinkers and typically, they begin drinking problematically, approximately around the age of 50. The research also compares them with their early-onset counterparts (people who begin drinking problematically, much earlier in life). Moreover, the research posits the notion that late-onset problem drinking in older adults is associated with a *lack of meaning and purpose in life*, resulting from major events that occur later in life, and investigates the role that *meaning and purpose in life* plays in both late- and early-onset problem drinking.

Who is eligible to participate in the study?

To take part in the study you must be:

1. 50 years-old or older
2. A *late-onset* drinker in recovery. That is, someone whose drinking became problematic at the age of 50 or later

   OR

   An *early-onset* drinker in recovery. That is, someone whose drinking became problematic earlier in life.

What does taking part involve?

Participating in the study involves completing two brief online questionnaires and a participant information form (age, gender, personal characteristics, etc.). **A QR code (and link) to the questionnaires is given at the end of this document.** The questionnaires are the *Purpose in Life Test* and the *Meaning in Life Questionnaire* (*MLQ*). Additionally, some people from both groups (i.e., late- and early-onset) will be invited to take part in an interview with myself. The duration of the interviews

will be between 30 and 45 minutes, and will be conducted online (Zoom, Microsoft Teams, Facetime etc.).

The interview will be recorded and later transcribed, analysed and interpreted. During the interview I will ask several 'open-ended' questions, meaning that you can answer the questions fully, rather than just giving "yes" "no" answers. If you decide that you would like to participate, your anonymity will be protected and you will be assigned a pseudonym, agreed prior to the interview. The assigned pseudonym will be used throughout the interview and will appear on the interview transcript.

What are the benefits of taking part?

By participating in the study, you will be contributing to a better understanding of how late-onset problem drinking develops in older adults, and how they recover from a problem that has seriously adverse consequences to their physical, psychological, and social well-being.

What if there is a problem?

If you have any concerns or complaints about anything to do with the study, please speak to the research team in the first instance (myself and my supervisors); we will do our best to answer your questions. Our contact details are available at the end of this information sheet.

Will the information I give in this study be kept confidential?

Yes, information collected from you will be kept confidential. This means that no one outside of the research team will see any of the information that has been generated by you. However, anonymised verbatim quotes from the interviews may be used as part of the research findings in the final written thesis and may be published. Each person taking part in the study will choose a unique participant code to store their data anonymously. In any subsequent material, including anything published; your identify is pseudonymized.

What will happen to the results of the study?

The information you give us will be analysed and written up; this will form part of my PhD thesis and may consequently be published and/or presented at academic conferences.

Has the research been ethically approved?

This study has been reviewed and approved for its ethical standards by the University of Derby, College of Business, Law and Social Sciences Research Ethics Committee, in accordance with the ethical guidelines of the British Psychological Society; a professional body of psychologists in the UK who overview research to ensure that it protects the safety, rights, well-being, and dignity of anyone who participates in research.

Can I withdraw from the research?

Should you so wish to withdraw from the research you may do so at any point, up to ten days after participation, you do not have to give a reason. To withdraw your data, simply contact the researcher quoting your unique participant code (you will be instructed to create at the beginning of the survey), stating that you wish to withdraw; we will destroy any information you have given us, including data collected during the study.

If I decide to participate, what do I do now?

If you have decided to take part in the questionnaire component of the study, thank you very much. All you need do now, is to scan the QR code below on your phone to access the study.

Alternatively, type this link into your browser:
https://derby.qualtrics.com/jfe/form/SV_ezYtCDqPnTRrpVc

Research Team Contact Details

Chief Investigator/Researcher	Kevin McInerney	k.mcinereny1@unimail.derby.ac.uk
Director of Studies	Professor David Best	d.best@derby.ac.uk
2nd Supervisor	Dr. Ainslea Cross	a.cross1@derby.ac.uk

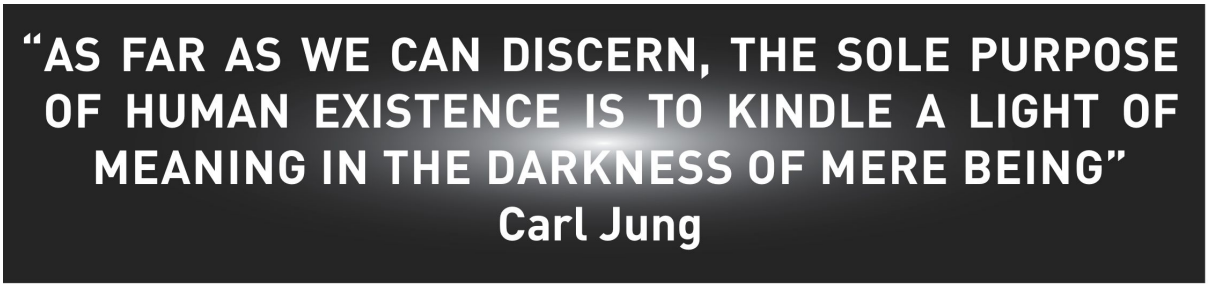
Thank you for taking the time to read this information sheet.

What role does Meaning and Purpose in Life play in Recovery from Problematic Drinking?

If you are fifty-years old or older, you are invited to take part in a psychological study, that simply involves completing a 15-minute survey.

Scan the QR code and go straight to the survey, OR type the link into your browser:

https://derby.qualtrics.com/jfe/form/SV_ezYtCDqPnTRrpVc



Contribute to an important and under-researched area of alcoholism and problem drinking.

I am in my 32nd year of recovery and I am currently undertaking a PhD, investigating late-onset problem drinking in people over 50; one-third of all older drinkers are late-onset.

If you 50 years-old and older, and in recovery, either late-onset or earlier-onset, I would be grateful if it you would undertake a survey at:

LATE-ONSET PROBLEM DRINKING

My thesis is framed within Viktor Frankl's theory of meaning and posits the notion that late-onset problematic drinking is associated with Frankl's concept of an existential vacuum (i.e., a lack of meaning and purpose in life).

Thank you

Kind regards
Kevin McInerney, MSc Health Psychology; BSc (Hons) Psych (Open); MBPsS

Facebook groups used for recruitment.

12 Steps The Solution AA (Alcoholics Anonymous)

AA Online Meetings, Information, Links, Support

Addiction Really

Addiction to Recovery

Alcohol & Sobriety: How to Control Drinking in the 21st Century

Alcohol and Drug Abuse Solutions

Alcoholics & Addicts Recovery Open Discussion

Alcoholics Anonymous Old Timers Living Sober Newcomers Welcome

Be Sober — Quit Drinking & Enjoy Life

Clean & Sober Recovery Group

Dear Struggling Addict

Friends of SMART Recovery and Harm Reduction

Hippies in Recovery

Punks in Recovery

Recovery Connections

Recovery From Addiction is possible

Recovery Revolution

Recovery Vibes

Smart Recovery

SMART Recovery Friends & Facilitators

Sobalicious

Sober Nation Addiction Support

Sobriety is Awesome

Solutions to Addictions

South London Kent Recovery

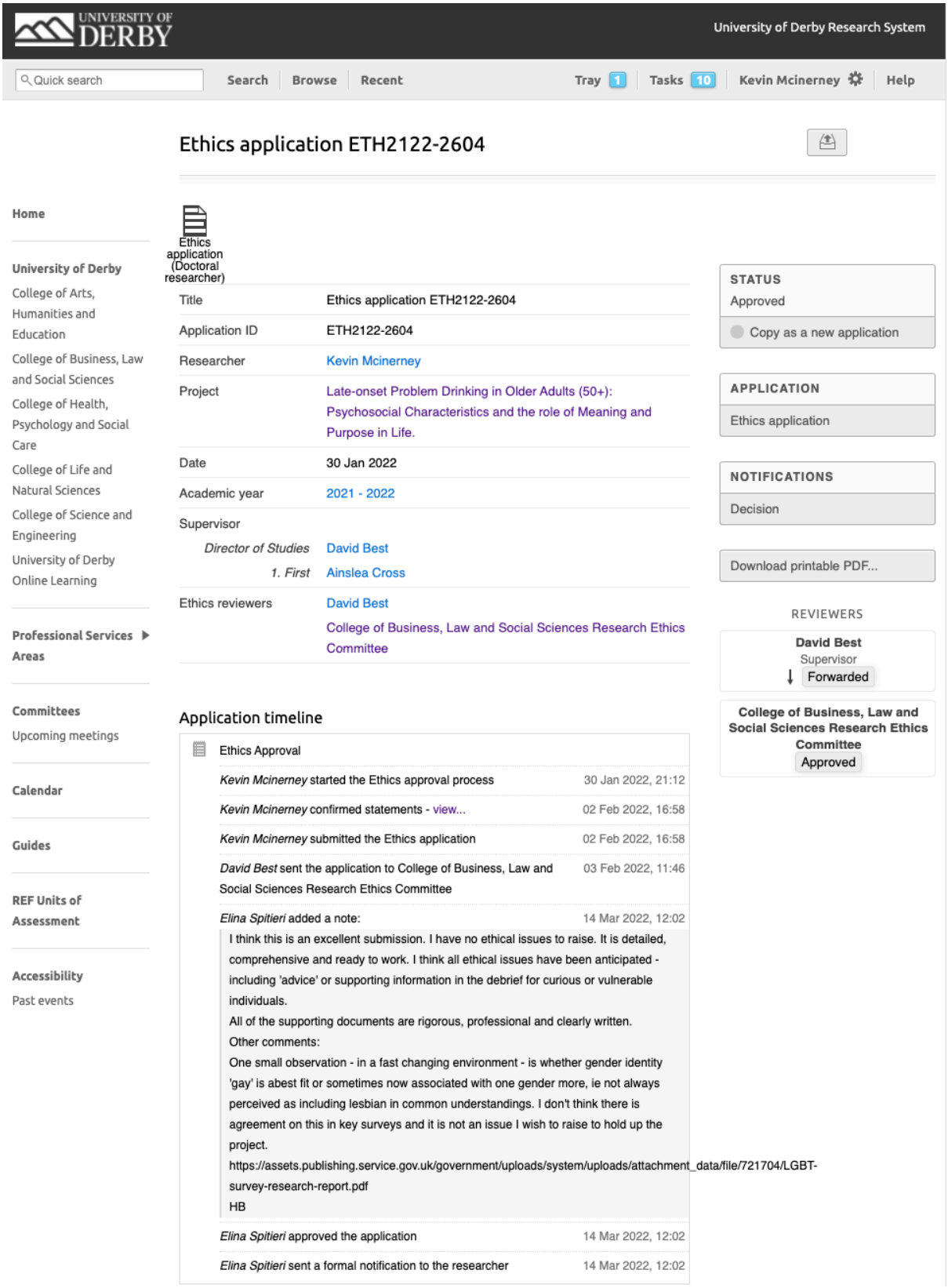
Support in Recovery From Alcohol & Drugs USA

There is Life after Addiction

This Side of Alcohol

Tribe Sober

N.B. These Facebook posts were continually reviewed, and the research summary text and survey link, inviting people to participate in the survey, was regularly re-posted so that it appeared at the top of the page to achieve a better response rate.


UNIVERSITY OF DERBY
University of Derby Research System
Quick search
Search
Browse
Recent
Tray 1
Tasks 10
Kevin Mcinerney
Help
Ethics application ETH2122-2604
Home
University of Derby
College of Arts, Humanities and Education
College of Business, Law and Social Sciences
College of Health, Psychology and Social Care
College of Life and Natural Sciences
College of Science and Engineering
University of Derby Online Learning
Professional Services Areas
Committees
Upcoming meetings
Calendar
Guides
REF Units of Assessment
Accessibility
Past events
Ethics application (Doctoral researcher)
Title
Ethics application ETH2122-2604
Application ID
ETH2122-2604
Researcher
Kevin Mcinerney
Project
Late-onset Problem Drinking in Older Adults (50+): Psychosocial Characteristics and the role of Meaning and Purpose in Life.
Date
30 Jan 2022
Academic year
2021 - 2022
Supervisor
Director of Studies
David Best
1. First
Ainslea Cross
Ethics reviewers
David Best
College of Business, Law and Social Sciences Research Ethics Committee
STATUS
Approved
Copy as a new application
APPLICATION
Ethics application
NOTIFICATIONS
Decision
Download printable PDF...
REVIEWERS
David Best
Supervisor
Forwarded
College of Business, Law and Social Sciences Research Ethics Committee
Approved
Application timeline
Ethics Approval
Kevin Mcinerney started the Ethics approval process
30 Jan 2022, 21:12
Kevin Mcinerney confirmed statements - view...
02 Feb 2022, 16:58
Kevin Mcinerney submitted the Ethics application
02 Feb 2022, 16:58
David Best sent the application to College of Business, Law and Social Sciences Research Ethics Committee
03 Feb 2022, 11:46
Elina Spitieri added a note:
14 Mar 2022, 12:02
I think this is an excellent submission. I have no ethical issues to raise. It is detailed, comprehensive and ready to work. I think all ethical issues have been anticipated - including 'advice' or supporting information in the debrief for curious or vulnerable individuals.
All of the supporting documents are rigorous, professional and clearly written.
Other comments:
One small observation - in a fast changing environment - is whether gender identity 'gay' is abest fit or sometimes now associated with one gender more, ie not always perceived as including lesbian in common understandings. I don't think there is agreement on this in key surveys and it is not an issue I wish to raise to hold up the project.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721704/LGBT-survey-research-report.pdf
HB
Elina Spitieri approved the application
14 Mar 2022, 12:02
Elina Spitieri sent a formal notification to the researcher
14 Mar 2022, 12:02

Health Research Authority

East Midlands - Leicester South Research Ethics Committee
Equinox House
City Link
Nottingham
NG2 4LA

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

15 August 2022

Mr Kevin McInerney
11 Coombe Court
Station Approach Road
Tadworth
KT20 5AL

Dear Mr McInerney

Study title:	**Late-onset Problem Drinking in Older Adults (50+): Psychosocial Characteristics and the role of Meaning and Purpose in Life.**
REC reference:	**22/EM/0162**
Protocol number:	**N/A**
IRAS project ID:	**314610**

Thank you for your letter of 08 August 2022, responding to the Research Ethics Committee's (REC) request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit:
https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at:
https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

After ethical review: Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS/HSC sites

I am pleased to confirm that the favourable opinion applies to any non-NHS/HSC sites listed in the application, subject to site management permission being obtained prior to the start of the study at the site.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [REC Unfavourable Opinion Letter]		31 May 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Confirmation of Insurance]	V1	01 August 2021
IRAS Application Form [IRAS_Form_30062022]		30 June 2022
Letter from statistician [2_Statistical_Advice__&_Power_Calculation_V2]	V2	10 June 2022
Non-validated questionnaire [Demographic questionnaire]		05 August 2022
Other [Cover Letter - Explanation of amendments undertaken to address the points of concern raised by the previous REC - Yorkshire & The Humber South Yorkshire REC]	1.0	17 July 2022
Participant consent form [Informed consent form for questionnaires]	3	05 August 2022
Participant information sheet (PIS)	4	11 August 2022
Protocol	3	07 August 2022
Referee's report or other scientific critique report [University of Derby Ethical Approval]	V1	30 January 2022
Referee's report or other scientific critique report [Suitability of Researcher]	V1	20 February 2022
Response to Request for Further Information [Response to Assessment Queries]		08 August 2022
Response to Request for Further Information [Response to Ethical Review Action Points]		08 August 2022
Summary CV for Chief Investigator (CI) [CV]		30 March 2022
Summary CV for supervisor (student research) [CVs_Biographies_of_Supervisors]	V1	15 April 2022
Validated questionnaire [MLQ]	V1	28 March 2022
Validated questionnaire [PIL Test]	V1	28 March 2022

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at:
https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 314610 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp.

Dr Nana Theodorou
Chair

Email: leicestersouth.rec@hra.nhs.uk

Enclosures: "After ethical review – guidance for researchers" [SL-AR2]

After ethical review guidance for sponsors and investigators –
Non CTIMP Standard Conditions of Approval

Copy to: Professor David Best

Lead Nation
England: approvals@hra.nhs.uk

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mr Kevin McInerney
PhD Student
Individual
11 Coombe Court
Station Approach Road
Tadworth
KT20 5ALN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

15 August 2022

Dear Mr McInerney

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Late-onset Problem Drinking in Older Adults (50+): Psychosocial Characteristics and the role of Meaning and Purpose in Life.'Problem Drinking' is defined as: Regularly drinking alcohol, above the recommended limits, in such a way that it impacts negatively on the physical and mental health and other aspects of a person's life.**
IRAS project ID:	**314610**
Protocol number:	**N/A**
REC reference:	**22/EM/0162**
Sponsor	**The University of Derby**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **314610**. Please quote this on all correspondence.

Yours sincerely,

HKPoole

Helen Poole
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Professor David Best*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [REC Unfavourable Opinion Letter]		31 May 2022
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Confirmation of Insurance]	V1	01 August 2021
IRAS Application Form [IRAS_Form_30062022]		30 June 2022
Letter from statistician [2_Statistical_Advice__&_Power_Calculation_V2]	V2	10 June 2022
Non-validated questionnaire [Demographic questionnaire]		05 August 2022
Organisation Information Document	3	15 April 2022
Other [Cover Letter - Explanation of amendments undertaken to address the points of concern raised by the previous REC - Yorkshire & The Humber South Yorkshire REC]	1.0	17 July 2022
Participant consent form [Informed consent form for questionnaires]	3	05 August 2022
Participant information sheet (PIS)	4	11 August 2022
Protocol	3	07 August 2022
Referee's report or other scientific critique report [University of Derby Ethical Approval]	V1	30 January 2022
Referee's report or other scientific critique report [Suitability of Researcher]	V1	20 February 2022
Response to Request for Further Information [Response to Assessment Queries]		08 August 2022
Response to Request for Further Information [Response to Ethical Review Action Points]		08 August 2022
Schedule of Events or SoECAT	3	
Summary CV for Chief Investigator (CI) [CV]		30 March 2022
Summary CV for supervisor (student research) [CVs_Biographies_of_Supervisors]	V1	15 April 2022
Validated questionnaire [MLQ]	V1	28 March 2022
Validated questionnaire [PIL Test]	V1	28 March 2022

IRAS project ID	314610

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is only one participating NHS organisation therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	The sponsor has detailed its proposals with respect to whether any study funding will be provided to participating NHS organisations of this type in the relevant Organisational Information Document. This should be read in conjunction with the relevant Schedule of Events/SoECAT which details the cost implications of the study for participating NHS organisations.	In line with HRA/HCRW expectations a Principal Investigator should be appointed at participating NHS organisations of this type.	Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed).These should confirm Occupational Health Clearance. These should confirm standard DBS checks. Use of identifiable patient records held by an NHS organisation to identify potential participants should be undertaken by a member of the direct care team for the patient, so it would not normally be acceptable for this to be done by staff not employed by that organisation.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Informed Consent Form to complete two questionnaires

Project title: Late-onset Problem Drinking in Older Adults (50+): Psychosocial Characteristics and the role of Meaning and Purpose in Life.

Research Team Contact Details

Chief Investigator	Kevin McInerney	k.mcinerney1@unimail.derby.ac.uk
Director of Studies	Professor David Best	d.best@leedstrinity.ac.uk
2nd Supervisor	Dr. Ainslea Cross	ajac1@le.ac.uk

Thank you for your interest in taking part in this research, which requires you to complete two questionnaires and a personal information form.

Anonymous word-for-word quotes from the interview may be used as part of the research findings in the final written thesis and may also be published. **There will be no reference to real names or any identifying details of the participant in any written reports**.

Please initial boxes

1. I confirm that I have read the Participant Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand the anonymous information collected about me may be used to support other research in the future and may be shared anonymously with other researchers. ☐
4. I understand that the anonymous information collected about me may be presented at academic Conferences and used in reports and academic publications. ☐
5. I have read and understand the above statements and agree to take part in this study. ☐

Your Date of Birth ☐☐☐☐☐☐

Participant Signature _____ Date _____

Name of person seeking consent _____ Date _____

Signature of person seeking consent _____

Hi Liz,

Thank you for getting back to me with these dates, I will send you a Teams link for 10.30 for Friday (29th). You are probably familiar with Teams, but if not, you do not need the app, you can just click on the link, and it will open in your browser.

Just to refresh your memory, my research investigates the psychological and social characteristics of older adults who begin drinking problematically later in life, referred to as 'late-onset'. Late-onset drinkers account for one-third of all older problem drinkers and typically, they begin drinking problematically, approximately around the age of 45-50.

The research also compares late-onset problem drinkers with their early-onset counterparts (people who begin drinking problematically, earlier in life). The research posits the notion that late-onset problem drinking in older adults is associated with a *lack of meaning and purpose in life*, resulting from major events that occur later in life, and investigates the role that *meaning and purpose in life* plays in both late- and early-onset problem drinking. To that end, I will be asking questions about your lived experience of active problem drinking and why you drank, and importantly about your subsequent recovery.

If you feel uncomfortable about any of the interview questions, you do not have to answer them, and you can stop the interview at any time you wish.

I have also attached a consent form (Word format), which you can initial and send back to me, OR if you have the facilities, you can print, sign, scan and send the form back to me. The form explains that that all your information is treated anonymously. Your name will be changed, and therefore you cannot be identified if any quotes from your interview are used in any subsequent digital or printed material.

Jackie — Experiental Statements pre-recovery

Emotional stability affected by the environment. 30-32

Working environment perceived as a drinking culture. 35-37

Inability to moderate alcohol consumption. 57-60

A written record of emotions and relationships. 76-77

Writing as a justification for drinking. 73-74

Amphetamines allowed her to drink more. 76-77

Using marriage as a conduit to emotional stability. 97-98 & 99-102

Dependent drinking conceptualised as stages. 105-107

Tendency to gravitate to like-minded drinkers. 35-37

Alcohol used to cope with anxiety. 48-56

Inability to recognise and appreciate social norms. 60-64

Disregard for personal safety and well-being. 79-82

Acceptance of a negative state of being. 81-82

Disregard for personal safety and well-being. 79-82

Increase in drinking after the loss of her father. 94-96

Negative emotions creating a negative sense of self. 161-162 162-164 166-167 167-170

Clinical diagnosis of depression. 137-139

Alcohol and drugs acknowledged as coping mechanisms when drinking. 148-150

Critique of self and ones' character. 140-143 & 143-145

Mental states negatively affected by excessive alcohol consumption. 156-157

An outsider perspective on Jackie's drinking. 178-179

Denial as a reality filter. 182-183

Memory blackouts accompany alcoholic drinking. 184-187

The beginning of a realisation of the dangers of alcoholic drinking. 188-190

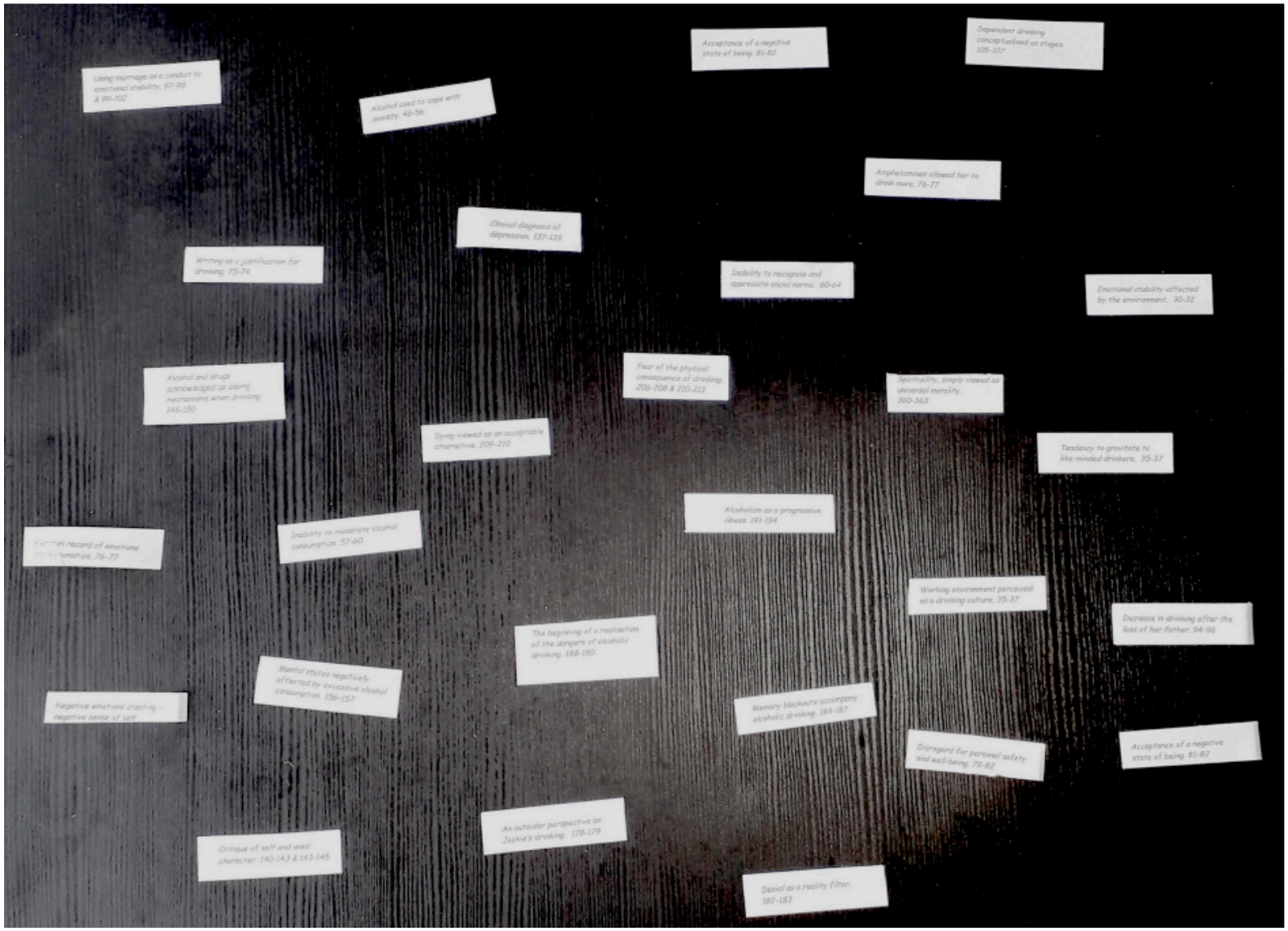
Alcoholism as a progressive illness. 191-194

Fear of the physical consequence of drinking. 206-208 & 210-213

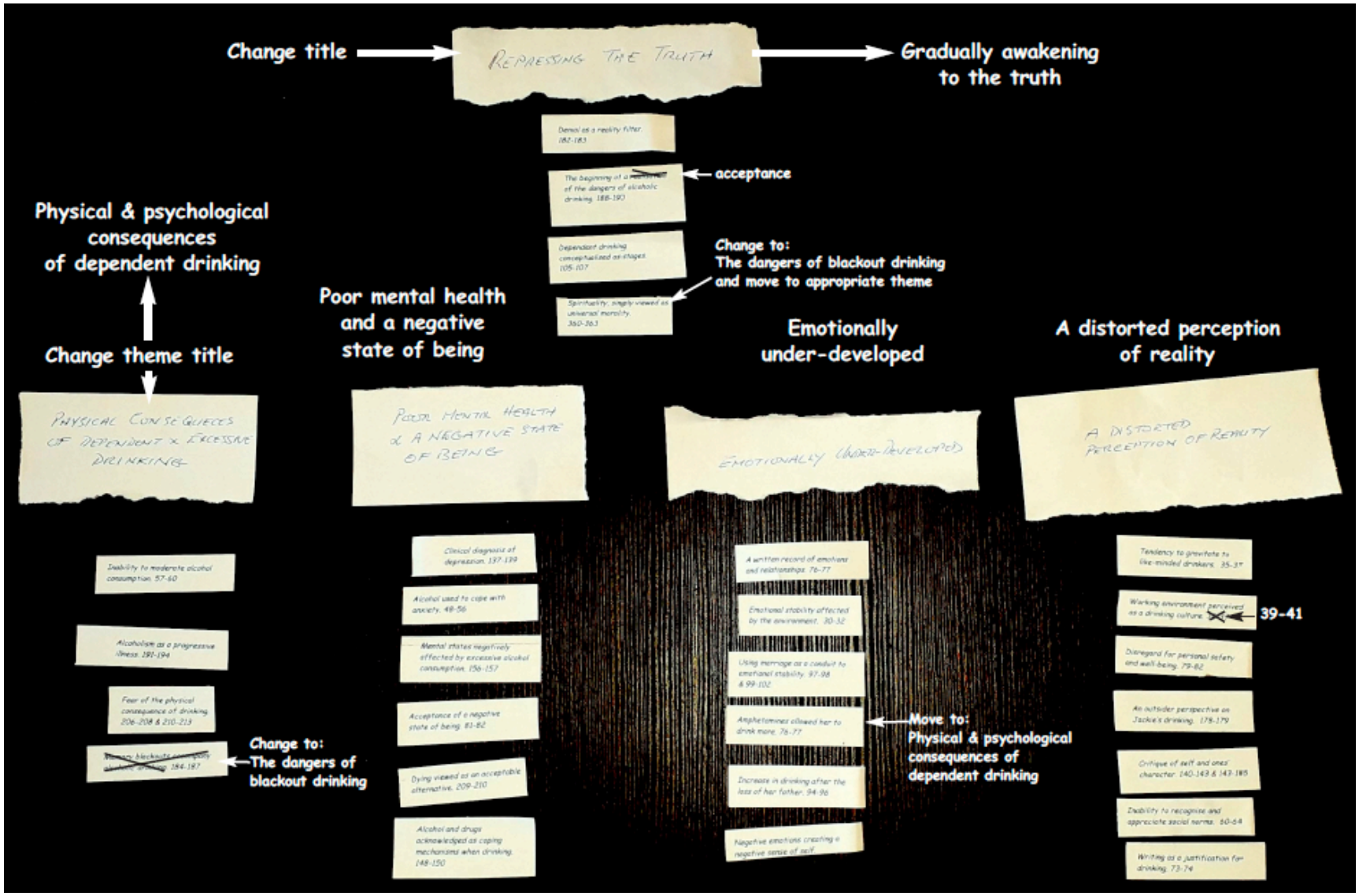
Dying viewed as an acceptable alternative. 209-210

Spirituality, simply viewed as universal morality. 360-363

Jackie — pre-recovery experiential statements for clustering



Jackie — pre-recovery experiential statements clustered into personal experiential themes



Jackie — Recovery Experiental Statements

Change of environment as a pivotal and influential factor on sobriety, 116-117

Major, emotional challenges negotiated in sobriety. 121-123

Sobriety as a multi-factorial phenomenon. 116-119

Major, emotional challenges negotiated in sobriety. 121-123 &145-147

The power of identification to heal. 200-204

Unmanagability around romantic relationships 239-241 & 241-245

Using the support of her recovery network. 254-256

Views recovery as being benefical as she ages 276-278

Defiance, as an alcoholic characteristic. 216-217 & 220-222

A gradual acceptance of ageing. 254-258, 261-262, 266-267 & 270-272

Struggling to fill the internal void. 293-294

Meaning found in service to others. 295-297, 297-298 & 298-300

Anxiety about letting go of AA. 316-317, 317-318, 320-321, 324 & 334-335

Spirituality, simply viewed as universal morality. 340-341, 347-348, 348-349 & 350-351

Vulnerability in early recovery. 368-369 & 371-373

Realising the nature of being. 375-378, 380-382, 382-384 & 384-386

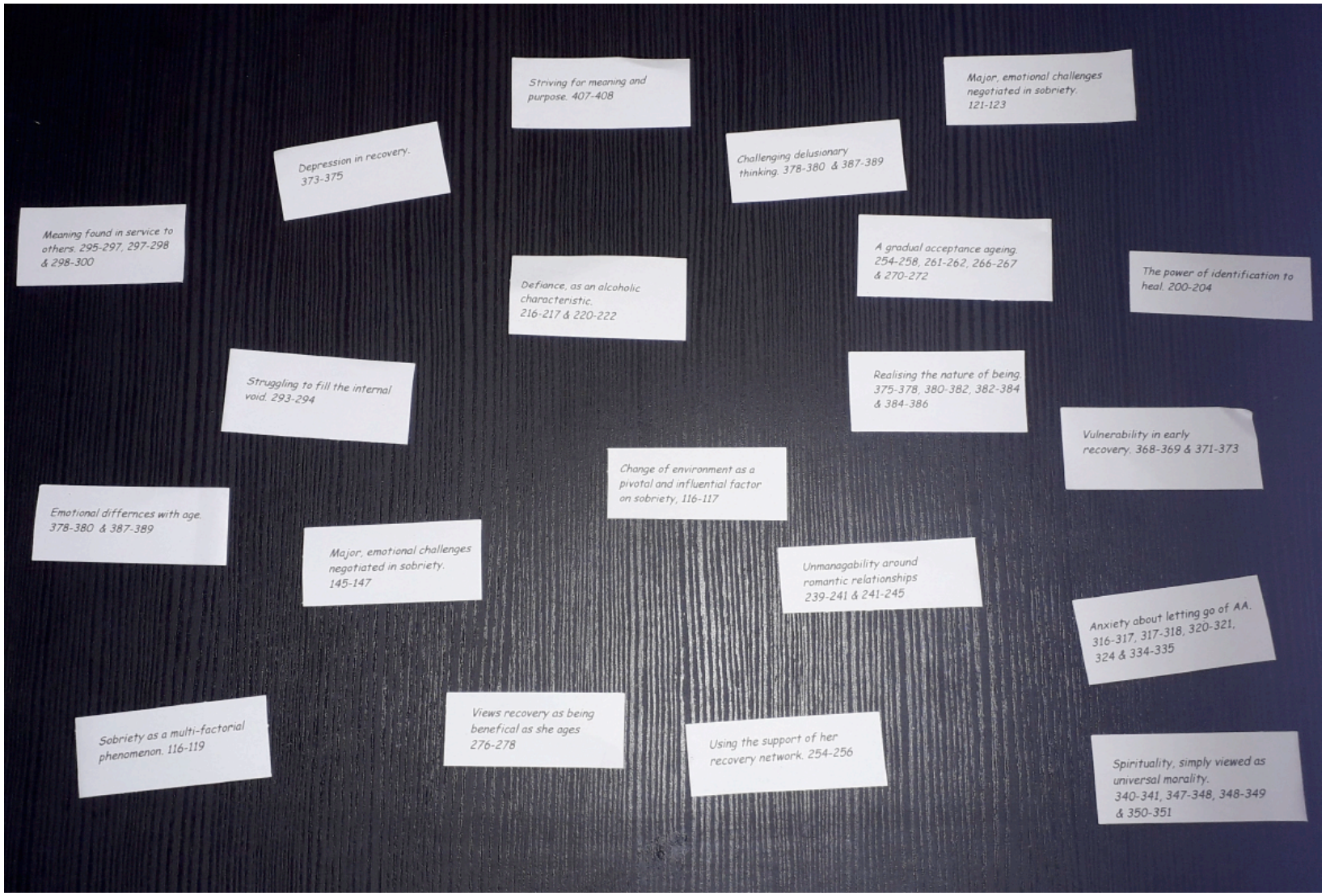
Challenging delusionary thinking. 378-380 & 387-389

Emotional differnces with age. 378-380 & 387-389

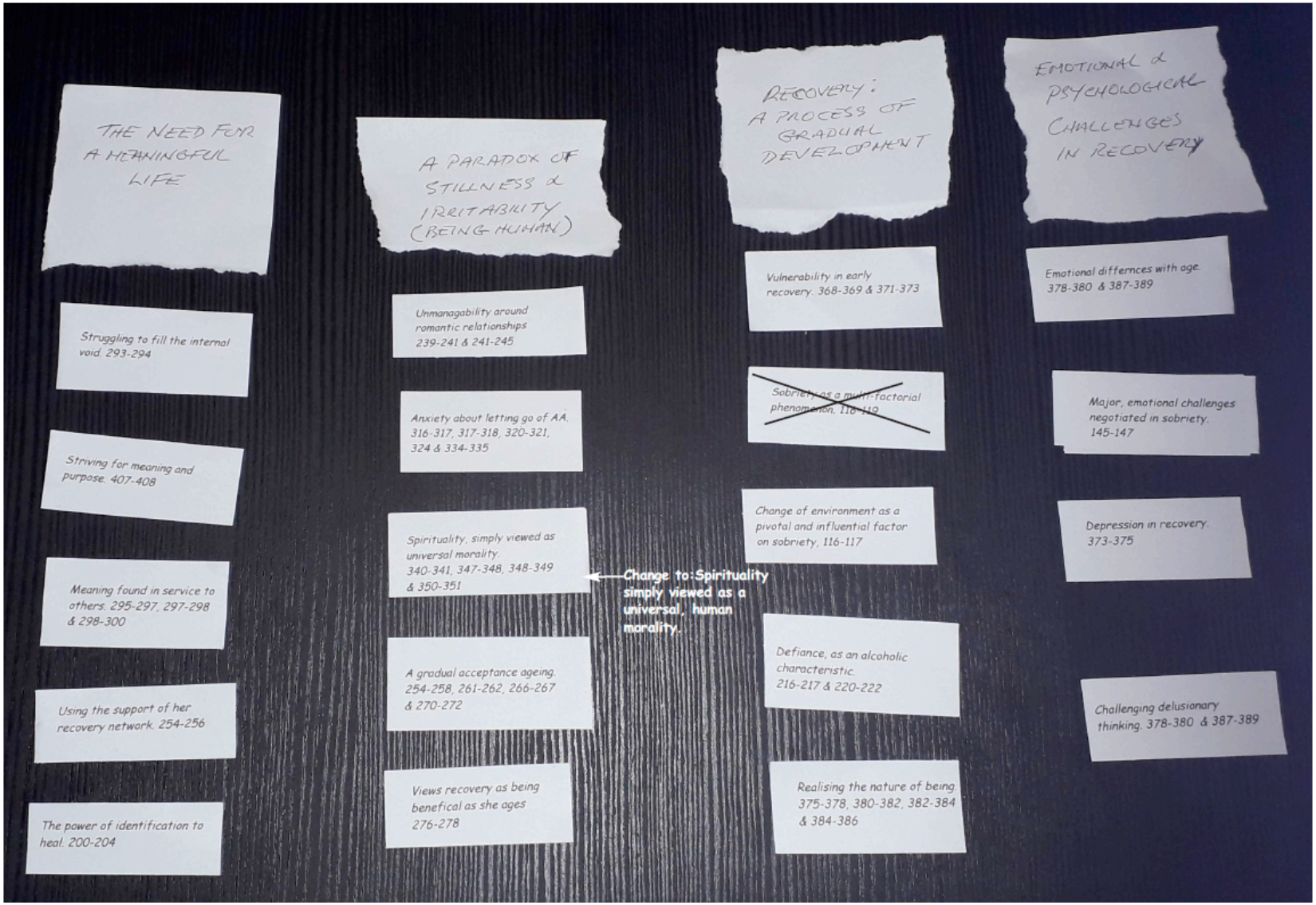
Striving for meaning and purpose. 407-408

Depression in recovery. 373-375

Jackie — Recovery experiential statements for clustering



Jackie — Recovery experiential statements clustered into personal experiential themes



Appendix 4.5 — 'ACTIVE' Drinking Personal Experiential Themes (PETs) & Statements EXAMPLE

Appendix 4.5.EO.1

Table of **ACTIVE DRINKING**
Personal Experiential Themes and Statements for Andy.

Key to themes:

1. **Paternal influence started at a young age.**
2. **Environmental influence at a young age.**
3 **Self-medicating to cope with depression and stress.**
4. **Inability to control or moderate drinking.**
5. **Emotional and personality changes, resulting from heavy drinking.**

Themes (& statements)	**Page & line**	**Quotes**
Paternal influence started at a young age.		
His father normalised a working-class drinking culture.	8 178-180	*My father also made it seem acceptable to drink at work. He would frequently come home for the weekend on a Friday afternoon, either a little bit earlier or very much later than usual, pissed.*
His father normalised a working-class drinking culture.	8 185-186	*...there was also the culture of feeling that you deserved it, because they'd worked you hard that week.*
His father's drinking related to World War II trauma.	8 194-196	*I realised that he was bringing home, bringing problems from work and hangover problems from the Second World War into his, into his domestic life.*
His father's drinking related to World War II trauma.	9 223-224	*...when the Krauts were still lobbying the occasional shell on to the beach.*
Influenced and negatively affected by his father's drinking.	8/9 200-202	*Sometimes he was a pig to my mum. And sometimes my myself and my sister were a little bit frightened with the idea of him coming home, we didn't know who he'd be.*
Influenced and negatively affected by his father's drinking.	9 210-212	*...drinking wine at home with a meal, maybe have a whiskey after dinner sometimes, but not always and I mean, he wasn't by any means sober...*
Influenced and negatively affected by his father's drinking.	9 226-227	*...but, ehm, he saw some things, but again, he didn't talk about them.*
Encouraged by his father's drinking.	9 203-204	*Ehm, I'm pretty sure he gave me my first drink.*
Environmental influence at a young age.		
Introduction to heavy drinkin at a young age.	3 67-69	*...if you call drinking problematically drinking so much that you're sick on the way home from the pub, then probably that would mean sixteen.*
Serious physical consequences of drinking at a young age.	4 83	*I was diagnosed with pancreatitis.*
Perception of the eighties as a drinking culture.	7 172-173	*...in the early nineteen-eighties that was pretty much the culture...*

Appendix 4.5 — 'ACTIVE' Drinking Personal Experiential Themes (PETs) & Statements EXAMPLE

Appendix 4.5.EO.1

Table of **ACTIVE DRINKING**
Personal Experiential Themes and Statements for Andy.

Themes (with statements)	**Page & line**	**Key phrase**
Encouraged to drink at a young age from role models.	7 173-174	*...my boss himself, you know, he used to stagger in about half eleven when he was meant to be in by ten o'clock.*
Encouraged to drink at a young age from role models.	7/8 175-178	*It was no example to me, I mean, I was nineteen and he was twenty-one. We were both as bad as each other, but he was my boss he made it seem acceptable.*
Self-medicating to cope with depression and stress.		
Self-medicating to cope with work-related stress.	4 94-96	*I was using that as an excuse to grab a beer on the way home from work and be stressed de-pressurised*
Clinical diagnosis of depression.	5 123-124	*Depression. I've been, well, I've been depressed, ehm, under the care of a doctor, one or another, since I was about sixteen.*
Self-medicating with alcohol to manage depression.	6 125-127	*found that although it is a depressant, alcohol helped me cope with the symptoms of depression, either by nullifying them, cutting them out completely, or allowing me to function, but I needed more...*
Depression as a chronic illness.	6 128-129	*Even, even now, I mean, I'm very rarely that far from bursting into tears over nothing...*
Alcohol as a coping mechanism.	14 336-338	*...she found it completely understandable, you know, what I was going through at work and at home.*
Alcohol as a coping mechanism.	14 339-340	*Ehm, but I've never been so rudely treated by the management of any company...*
Alcohol as a coping mechanism.	14 341-342	*...they hated us, called us skivers, bad drivers, ehm, didn't pay attention, in their opinion.*
Inability to control or moderate drinking.		
Inability to stay stopped.	4 87-88	*So, for quite some time I was completely alcohol-free. Ehm, but then it started to creep up, creep up again.*
Inability to moderate drinking.	4 96-97	*...again, that started off moderately and pretty soon increased to it becoming problematic...*
Guilt and denial, manifested in hiding alcohol.	4 97-98	*I was hiding it from the partner?*
Drinking to oblivion (blackout drinking).	7 161-162	*I wanted to shut out the outside world.*
Judgementalism as a manifestation of denial.	11 272-273	*I wasn't a problematic drinking in the way of some of the other people in that group were.*

Appendix 4.5 — 'ACTIVE' Drinking Personal Experiential Themes (PETs) & Statements EXAMPLE

Appendix 4.5.EO.1

Table of **ACTIVE DRINKING**
Personal Experiential Themes and Statements for Andy.

Themes (with statements)	**Page & line**	**Key phrase**
Emotional and personality changes resulting from heavy drinking.		
Feelings of incompleteness witout alcohol.	3 71-72	*...but inside I, I, I felt that I was playing a part.*
Alcohol changed his feelings, his personality, and his identity.	3/4 72-74	*...alcohol dispensed with the feeling of playing a part and made me feel that I was the life and soul of the party...*
Devious, guilt-ridden drinking behaviour.	9 245-246	*I was hiding my drinking from my partner and I kept engineering it so that I got found out.*
Devious, guilt-ridden drinking behaviour.	9 248-249	*But I was drinking on the sly, and I was drinking out of her bottle, so she was bound to notice.*
Unconscious manipulative behaviour to deal with his feelings.	11 253-254	*I made sure that .... as I say, I engineered being discovered...*
Unconscious manipulative behaviour to deal with his feelings.	11 256-257	*...it's not something I'm doing consciously...*
Unconscious manipulative behaviour to deal with his feelings.	11 257-259	*I was trying to ask for help with the way I felt. But what I actually did was just to generate anger and sadness on her part.*
Inability to ask for help, driven by false pride.	11 259-260	*I needed to be more direct with her, I needed to ask her for her assistance.*

Link to view tables for all participants' 'ACTIVE' drinking PETs and Statements:
https://drive.google.com/drive/folders/16wdq1AXQj5VnJARcWDew8Tz5bSebHfh_?usp=drive_link

***Pre-Recovery* Personal Experiential Themes for Andy**

Paternal influence started at a young age.
Environmental influence at a young age.
Self-medicating to cope with depression and stress.
Inability to control or moderate drinking.
Emotional & personality changes, resulting from heavy drinking.

***Pre-Recovery* Personal Experiential Themes for Heather**

A family culture that normalised heavy drinking.
Progressive drinking leading to inevitable loss of control.
Self-medicating with drugs and alcohol.
Personality and identity, core components of self, challenged.
Confirmation bias supported denial.

***Pre-Recovery* Personal Experiential Themes for Jackie**

A distorted perspective of reality.
Physical & psychological consequences of dependent drinking.
Emotionally underdeveloped.
Poor mental health and a negative state of being.
Gradually awakening to the truth.

***Pre-Recovery* Personal Experiential Themes for James**

Denial 1. A reluctance to accept that alcohol is the problem.
Denial 2. A warped perception supporting denial.
Alcohol viewed as an agent for coping with daily living.
An inability to control alcohol consumption.
Problematic drinking leading to social isolation.

***Pre-Recovery* Personal Experiential Themes for Liz**

Alcohol used a coping mechanism.
Loss of control 1.
Loss of control 2. A progressive phenomenon.
A negative state of being 1. Poor mental health.
A negative state of being 2. Negative emotions, behaviour & thoughts.

***Pre-Recovery* Personal Experiential Themes for Michael**

Dependent drinking: a physical manifestation of a mental obsession.
Introduction to a drinking culture at a very young age.
Emotional immaturity leading to low self-worth.
Self-medicating to cope with a negative state of being.

Pre-Recovery **Personal Experiential Themes for Mike**

The negative influence of a family drinking culture.
Alcohol, an agent to manage emotions and personality.
Negatively reinforcing drinking behaviours.
Alcohol, as a coping mechanism for people and events.

Pre-Recovery **Personal Experiential Themes for Nora**

Dependent drinking 1. An obsession.
Dependent drinking 2. As a great remover.
A family illness from contrasting perspectives: influence and impact.
Denial manifested in a continuing cycle of sobriety and relapse.
Self-medicating to cope with mental health and emotions.
Existing (being) in a state of mental and emotional despair.

Pre-Recovery **Personal Experiential Themes for Sheila**

Emotions 1. An inability to cope with emotions.
Emotions 2. Alcohol as an emotional coping mechanism.
A negative impact on family relationships and dynamics.
Lack of control: a sign of dependent drinking.
Poor mental health, co-existing with self-loathing.

Recovery **Personal Experiential Themes for Andy**

Empathy born out of suffering.
Mental and emotional well-being.
Mutual-aid as an aspect of recovery capital.
A supportive family as an aspect of recovery capital.

Recovery **Personal Experiential Themes for Heather**

Negotiating a family drinking culture.
High levels of self-efficacy.
Mutual-aid groups and peers supporting sobriety.
Re-discovering and re-constructing self.
New meaning and purpose in life emerge in recovery.

Recovery **Personal Experiential Themes for Jackie**

The need for a meaningful life.
A paradox: stillness and irritability (being human).
Recovery: a process of gradual development.
Emotional and psychological challenges in recovery.

Recovery Personal Experiential Themes for James

Empathy and psychosocial integration.
Realising the influence of childhood experience.
Recovery as an agent for emotional maturity.
Meaning and purpose in life: vital to recovery.
An existential, secular spirituality.

Recovery Personal Experiential Themes for Liz

Empathy reinforcing recovery.
Identification: the key component of peer support.
Gradually feeling comfortable in society.
Self-efficacy viewed as personal agency.
Mental and emotional equilibrium.

Recovery Personal Experiential Themes for Michael

Freedom from fear and anxiety.
Mutual aid as a reciprocal concept.
Rediscovering a social identity.
Being part of an extended family.
AA as a way of life and an alternative identity.

Recovery Personal Experiential Themes for Mike

Managing the scars of imprinted family drinking behaviours.
Understanding of self-supporting high levels of self-efficacy.
The positive role of peers and mutual-aid groups in recovery.
Implied meaning and purpose in life.

Recovery Personal Experiential Themes for Nora

Mutual-aid and peer-support nurturing recovery.
Empathy and support for fellow sufferers reinforcing sobriety.
Mental, emotional and psychological stability.
Caring for loved ones gives life meaning and purpose.

Recovery Personal Experiential Themes for Sheila

A new pair of glasses: life viewed from a positive perspective.
A peaceful acceptance of family dynamics.
Meaning and purpose in life found in thinking of & caring for others.
A willingness to change: high value self-efficacy.

***Pre-Recovery* Personal Experiential Themes for Audrey**

A coping mechanism for anxiety.
Alcohol dependency 1: From occasional drinking to secret drinking.
Alcohol dependency 2: A transition from wanting to needing alcohol.
Delusional thinking as a form of denial.
Revolving door syndrome: A cycle of relapse and rehab.

***Pre-Recovery* Personal Experiential Themes for Claire**

Heavy drinker 1: A high tolerance for alcohol.
Heavy drinker 2: Progression from heavy to dependent drinker.
Identity: a life-long issue.
Psychoemotional challenges.

***Pre-Recovery* Personal Experiential Themes for Gary**

A gradual progression towards dependent drinking.
A history of poor mental health.
Alcohol as a coping mechanism for the stresses of daily living.

***Pre-Recovery* Personal Experiential Themes for Jack**

Adversely affected by major life events.
Loss of control: the paradox of controlled drinking.
From loss of control to alcohol dependency.
An existential vacuum.

***Pre-Recovery* Personal Experiential Themes for Kate**

Meaning and purpose in life was invested in her identity.
Loss of control: trying to replicate the feeling of the first drink.
A state of being leading to a feeling of emptiness.

***Pre-Recovery* Personal Experiential Themes for Kerry**

Identity crisis following career ending.
Problematic drinking as one extreme on a social drinking continuum.
Life-long mental health and neurological challenges.
Emotionally disconnected.

***Pre-Recovery* Personal Experiential Themes for Sarah**

Alcohol to cope with difficult life events and challenges to identity.
Growing up in an alcoholic home.
Transferring her childhood experiences to her own children.
An ego-driven and controlling personality.
Self-medicating poor mental health with alcohol.

***Pre-Recovery* Personal Experiential Themes for Steffen**

Major Life Events 1: A combination of major life events.
Major Life Events 2: His daughter's illness affected marriage & self.
Unresolved feelings of childhood abandonment.
Undiagnosed ADHD and emotional regulation.

Pre-Recovery **Personal Experiential Themes for Terry**

A coping mechanism for major life events.
Alcohol as a coping mechanism for anxiety.
Alcohol as a coping mechanism for fear.
A gradual progression from drinking to cope to dependent drinking.
An existential dilemma: an inability to cope with reality.

Recovery **Personal Experiential Themes for Audrey**

Taking positive advantage of one's lived experience.
The recovery capital of family: A supportive husband.
Being active and creative as antidotes to boredom.
A persistence and self-belief in maintaining recovery.

Recovery **Personal Experiential Themes for Claire**

Identity still an issue in recovery.
An internal vacuum after cessation of drinking.
Self-belief and determination.
A personality not compatible with mutual-aid support.
Helping others gives life meaning and purpose.

Recovery **Personal Experiential Themes for Gary**

Self-efficacy 1. Demonstrating abstinence self-efficacy.
Self-efficacy 2. Motivations to stop drinking.
Cultivating empathy as a way of being.
Finding a purpose in life.

Recovery **Personal Experiential Themes for Jack**

A combination of resilience and self-efficacy.
The support of family, friends and professionals as recovery capital.
Re-establishing a social identity.
Living a purposeful existence.

Recovery **Personal Experiential Themes for Kate**

Meaning and purpose found in community and connection
Motivated by a supportive family and friends.
High self-efficacy promoting self-development.
Being in the world in the present (temporality).

Recovery **Personal Experiential Themes for Kerry**

Clear purposes in life.
Self-efficacy promoting the necessary change needed in recovery.
Becoming comfortable in mutual-aid groups.
Recovery viewed as a family journey.

Recovery **Personal Experiential Themes for Sarah**

A change in attitudes and behaviour.
Having a purpose in life.
Nurturing healthier relationships with children and self.

Recovery Personal Experiential Themes for Steffen

Recovery as an existential choice.
A positive and life-changing diagnosis of ADHD.
Lived experience of addiction as a catalyst for helping others.
A supportive network as recovery scaffolding.

Recovery Personal Experiential Themes for Terry

Acceptance 1. A deep acceptance that he cannot drink.
Acceptance 2. Accepting life, reality and being in the world as it is.
Sharing lived experience with others is mutually beneficial.

Early-Onset PETs mapped on to Group Experiential Themes (GETs)

Pre-Recovery Voice — Group Experiential Theme 1

Emotional immaturity: drinking to change feelings
Emotional & personality changes, resulting from heavy drinking. (Andy)
Emotionally underdeveloped. (Jackie)
Alcohol used as a coping mechanism. (Liz)
A negative state of being 2. Negative emotions, behaviour & thoughts. (Liz)
Self-medicating to cope with a negative state of being. (Michael)
Emotional immaturity leading to low self-worth. (Michael)
Alcohol as a coping mechanism for people and events. (Mike)
Alcohol, an agent to manage emotions and personality. (Mike)
Negatively reinforcing drinking behaviours. (Mike)
Self-medicating to cope with mental health and emotions. (Nora)
Emotions 1. An inability to cope with emotions. (Sheila)
Emotions 2. Alcohol as an emotional coping mechanism. (Sheila)

Pre-Recovery Voice — Group Experiential Theme 2

Co-existing mental health challenges
Self-medicating to cope with depression and stress. (Andy)
Personality and identity, core components of self, challenged. (Heather)
Self-medicating with drugs and alcohol. (Heather)
Poor mental health and a negative state of being. (Jackie)
Problematic drinking leading to social isolation. (James)
A negative state of being 1. Poor mental health. (Liz)
Poor mental health, co-existing with self-loathing. (Sheila)
Existing (being) in a state of mental and emotional despair. (Nora)

Pre-Recovery Voice — Group Experiential Theme 3

Obsessive drinking manifested in an inability to stop or moderate
3a Loss of control leading to dependent drinking
Inability to control or moderate drinking. (Andy)
Progressive drinking leading to inevitable loss of control. (Heather)
Physical & psychological consequences of dependent drinking. (Jackie)
An inability to control alcohol consumption. (James)
Alcohol viewed as an agent for coping with daily living. (James)
Loss of control 1. (Liz)
Loss of control 2. A progressive phenomenon. (Liz)
Dependent drinking: a physical manifestation of a mental obsession. (Michael)
Dependent drinking 1. An obsession. (Nora)
Dependent drinking 2. Alcohol as a great remover (Nora)
Lack of control: a sign of dependent drinking. (Sheila)
3b Denial: an inability to accept and live in reality
Confirmation bias supported denial. (Heather)
A distorted perspective of reality. (Jackie)
Gradually awakening to the truth. (Jackie)
Denial 1. A reluctance to accept that alcohol is the problem. (James)
Denial 2. A warped perception supporting denial. (James)
Denial manifested in a continuing cycle of sobriety and relapse. (Nora)

Early-Onset PETs mapped on to Group Experiential Themes (GETs)

Pre-Recovery Voice — Group Experiential Theme 4

A reciprocal family dynamic: influence and impact
Environmental influence at a young age. (Andy)
Paternal influence started at a young age. (Andy)
A family culture that normalised heavy drinking. (Heather)
Introduction to a drinking culture at a very young age. (Michael)
The negative influence of a family drinking culture. (Mike)
A family illness from contrasting perspectives: influence and impact. (Nora)
A negative impact on family relationships and dynamics. (Sheila)

Recovery Voice — Group Experiential Theme 1

Mutual-aid and peer-support nurturing recovery
Mutual-aid as an aspect of recovery capital. (Andy)
Mutual-aid groups and peers supporting sobriety. (Heather)
AA as a way of life and an alternative identity. (Michael)
Mutual-aid as a reciprocal concept. (Michael)
The positive role of peers and mutual-aid groups in recovery. (Mike)
Identification: the key component of peer support. (Liz)
Mutual-aid and peer-support nurturing recovery. (Nora)

Recovery Voice — Group Experiential Theme 2

Abstinence self-efficacy: a primary mechanism of behaviour change
High levels of self-efficacy. (Heather)
Re-discovering and re-constructing self. (Heather)
Recovery: a process of gradual development. (Jackie)
Gradually feeling comfortable in society. (Liz)
Self-efficacy viewed as personal agency. (Liz)
Re-discovering a social identity. (Michael)
Nurturing self-efficacy by accepting the reality of being in the world. (Mike)
A new pair of glasses: life viewed from a positive perspective. (Sheila)
A willingness to change as high value self-efficacy. (Sheila)

Recovery Voice — Group Experiential Theme 3

Finding psychological and emotional equilibrium
Mental and emotional well-being. (Andy)
A paradox: stillness and irritability (being human). (Jackie)
Emotional and psychological challenges in recovery. (Jackie)
Recovery as an agent for emotional maturity. (James)
Mental and emotional equilibrium. (Liz)
Freedom from fear and anxiety. (Michael)
Mental, emotional and psychological stability. (Nora)

Early-Onset PETs mapped on to Group Experiential Themes (GETs)

Recovery Voice — Group Experiential Theme 4

Accepting and managing family dynamics in recovery
A supportive family as an aspect of recovery capital. (Andy)
Negotiating a family drinking culture. (Heather)
Realising the influence of childhood experience. (James)
Being part of an extended family. (Michael)
Managing the scars of imprinted family drinking behaviours. (Mike)
Reaching out (Sheila)

Recovery Voice — Group Experiential Theme 5

Empathy: reaching out to others gives life purpose and meaning
Empathy born out of suffering. (Andy)
New meaning and purpose in life emerge in recovery. (Heather)
The need for a meaningful life. (Jackie)
Empathy and psychosocial integration. (James)
Meaning and purpose in life: vital to recovery. (James)
An existential, secular spirituality. (James)
Empathy reinforcing recovery. (Liz)
Implied meaning and purpose in life. (Mike)
Caring for loved ones gives life purpose and meaning. (Nora)
Empathy and support for fellow sufferers reinforcing sobriety. (Nora)
Meaning and purpose in life found in thinking of & caring for others. (Sheila)

Pre-Recovery Voice — Group Experiential Theme 1

A gradual progression from social drinker to problem drinker
Alcohol dependency 1: From occasional drinking to secret drinking. (Audrey)
Alcohol dependency 2: A transition from wanting to needing alcohol. (Audrey)
Delusional thinking as a form of denial. (Audrey)
Revolving door syndrome: A cycle of relapse and rehab. (Audrey)
Heavy drinker 1: A high tolerance for alcohol. (Claire)
Heavy drinker 2: Progression from heavy to dependent drinker. (Claire)
From loss of control to alcohol dependency. (Jack)
Loss of control: the paradox of controlled drinking. (Jack)
An existential dilemma: an inability to cope with reality. (Terry)
A gradual progression from drinking to cope to dependent drinking. (Terry)
A gradual progression towards dependent drinking. (Gary)
Problematic drinking as one extreme on a social drinking continuum. (Kerry)
Loss of control: trying to replicate the feeling of the first drink. (Kate)
Major Life Events 1: A combination of major life events. (Steffen)

Pre-Recovery Voice — Group Experiential Theme 2

The impact of major life events on identity and self
Identity: a life-long issue. (Claire)
Alcohol as a coping mechanism for the stresses of daily living. (Gary)
Adversely affected by major life events. (Jack)
An existential vacuum. (Jack)
Meaning and purpose in life was invested in her identity. (Kate)
Identity crisis following career ending. (Kerry)
Alcohol to cope with difficult life events and challenges to identity. (Sarah)
Major Life Events 1: A combination of major life events. (Steffen)
Major Life Events 2: His daughter's illness affected marriage and self. (Steffen)
A coping mechanism for major life events (Terry)

Pre-Recovery Voice — Group Experiential Theme 3

Challenges to psychological, emotional and mental well-being
3a Alcohol as a coping mechanism for poor mental health.
A coping mechanism for anxiety. (Audrey)
Psycho-emotional challenges. (Claire)
A history of poor mental health. (Gary)
A state of being leading to a feeling of emptiness. (Kate)
Life-long mental health and neurological challenges. (Kerry)
Self-medicating poor mental health with alcohol. (Sarah)
An ego-driven and controlling personality. (Sarah)
Major Life Events 1: A combination of major life events. (Steffen)
Alcohol as a coping mechanism for anxiety. (Terry)
Alcohol as a coping mechanism for fear. (Terry)
3b Life-long psychological, emotional and neurological challenges.
Alcohol as a coping mechanism for the stresses of daily living. (Gary)
Emotionally disconnected. (Kerry)
Growing up in an alcoholic home. (Sarah)
Transferring her childhood experiences to her own children. (Sarah)
Undiagnosed ADHD and emotional regulation. (Steffen)
Unresolved feelings of childhood abandonment. (Steffen)

Recovery Voice — Group Experiential Theme 1

Abstinence self-efficacy: a primary mechanism of behaviour change
A persistence and self-belief in maintaining recovery. (Audrey)
Self-belief and determination. (Claire)
Self-efficacy 1. Demonstrating abstinence self-efficacy. (Gary)
Self-efficacy 2. Motivations to stop drinking. (Gary)
A combination of resilience and self-efficacy. (Jack)
High self-efficacy promoting self-development. (Kate)
Self-efficacy promoting the necessary change needed in recovery. (Kerry)
A positive and life-changing diagnosis of ADHD. (Steffen)
Acceptance 1. A deep acceptance that he cannot drink. (Terry)
Acceptance 2. Being present in the world and accepting reality. (Terry)

Recovery Voice — Group Experiential Theme 2

Connecting and being in the world with others
Taking positive advantage of one's lived experience. (Audrey)
Helping others gives life meaning and purpose. (Claire)
A personality not compatible with mutual-aid support. (Claire)
Meaning and purpose found in community and connection. (Kate)
Becoming comfortable in mutual-aid groups. (Kerry)
A change in attitudes and behaviour. (Sarah)
Lived experience of addiction as a catalyst for helping others. (Steffen)
Sharing lived experience with others is mutually beneficial. (Terry)

Recovery Voice — Group Experiential Theme 3

Recovery as a family journey
The recovery capital of family: A supportive husband. (Audrey)
Finding a purpose in life. (Gary)
The support of family, friends and professionals as recovery capital. (Jack)
Motivated by a supportive family and friends. (Kate)
Recovery viewed as a family journey. (Kerry)
Nurturing healthier relationships with children and self. (Sarah)
A supportive network as recovery scaffolding. (Steffen)

Recovery Voice — Group Experiential Theme 4

Having a purpose gives life meaning
Being active and creative as antidotes to boredom. (Audrey)
Helping others gives life meaning and purpose. (Claire)
Identity still an issue in recovery. (Claire)
Filling an internal vacuum after cessation of drinking. (Claire)
Finding a purpose in life. (Gary)
Living a purposeful existence. (Jack)
Being in the world in the present (temporality). (Kate)
Clear purposes in life. (Kerry)
Having a purpose in life. (Sarah)
Recovery as an existential choice. (Steffen)
Acceptance 2. Being present in the world and accepting reality. (Terry)

Some of the participants' 'personal experiential themes' — dependent on the 'experiential statements' contained with the theme — map onto more than one 'group experiential theme'. For example, *Finding a purpose in life* (Gary) maps onto Recovery Voice Group Experiential Themes 3 and 4; *Recovery as a family* journey and *Having a purpose gives life meaning*, respectively.

Glatt's Chart (AKA Jellinek's Curve): a brief history. Deconstructing a 70-year-old myth.

In 1960, *the Disease Concept of Alcoholism* (Jellinek, 1960), was published; Jellinek's seminal work was the culmination of a process that he had started 14 years earlier (Jellinek, 1946). The data for Jellinek's 1946 study had been collected from members of Alcoholics Anonymous (A.A.), who had completed a questionnaire, distributed via the A.A. magazine, Grapevine. In the study, Jellinek aimed to determine the biopsychosocial characteristics of alcoholics and the various stages that constitute the descent into chronic alcoholism. In his paper, Jellinek presents several phases, (e.g., prodromal, chronic) and symptoms, (e.g., persistent remorse, protecting supply, tremors, indefinable fears), describing the progression of alcoholism. Later, Jellinek (1952) undertook another study on a much larger sample of approximately 2,000 recovering alcoholics (again, A.A. members) and distributed his own considerably detailed questionnaire. From this much more comprehensive data set, Jellinek elaborated further on his original concept, including a linear chart, which graphically described the process towards alcohol dependency (Jellinek, 1952). The chart (Figure 1) shows a 'pre-alcoholic phase', comprised of three symptoms, and a further three phases, which were populated by 43 progressively worsening symptoms. Unintentionally, Jellinek's paper on the 'Phases of Alcohol Addiction' (Jellinek, 1952) became the kindling that ignited a myth that has been propagated for the last seven decades. The myth concerns what is typically, and mistakenly, referred to as Jellinek's Curve', a graphic chart, that maps the spiralling descent toward alcohol dependency, and the stages of rehabilitation.

However, the evidence unequivocally supports the notion that the 'Jellinek Curve' was conceived, not by Jellinek, but by psychiatrist, Max Glatt, and should, arguably, and justifiably, be referred to as Glatt's Chart (1958); attributing the curve concept to Jellinek, continues to reinforce a 70-year-old myth. Jellinek's (1952) linear chart, for example, makes no reference, whatsoever, to rehabilitation or recovery, rather his chart only explains the processes involved in the formation of alcohol dependency. The idea of a more holistic model, that includes a process of rehabilitation/recovery, as well as the phases of dependency, was conceived by Glatt (1958). Glatt's V-shaped chart, or curve (Figure 2), plots the progressive phases and symptoms of the descent towards an alcoholic "rock bottom" (downward slope), and the subsequent phases and stages of rehabilitation

(upward slope). Closer inspection of figure 2 (see bottom, right-hand corner) shows that Glatt had first imagined the addiction/recovery model in 1954, just two years after Jellinek's (1952) phases concept was published. That same year, Glatt founded the first NHS alcohol rehabilitation unit in the UK, Pinel House, at Warlingham Park Hospital, Croydon, just outside London* (see Glatt, 1955,1991).

The addiction slope of Glatt's Chart was initially based on Jellinek's phases and symptoms of alcohol dependence. The symptoms on the rehabilitation phase slope, solely created and developed by Glatt were based on the lived experiences of many of his Pinel House ex-patients, who also attended A.A. meetings. The former patients held monthly reunions, where they would 'share' about their experiences and challenges in early recovery (Glatt, 1958), which Glatt referred to as "rehabilitation problems" (p. 138). Glatt (1970) later edited and refined his Chart (Figure 3), and it is that more familiar version, that is typically referred to as the 'Jellinek Curve'. The title on his initial sketch, which was slightly amended from, 'A chart of alcohol addiction and recovery', to the more cautious title, 'A tentative chart of alcohol addiction' (on the later version), suggests perhaps, that the chart was a 'work in progress', and not his final and definitive model of alcohol dependency and recovery. Additionally, as well as conceiving a complete model of alcohol dependency and recovery that included adding a rehabilitation phase to Jellinek's dependency phases, Glatt changed much of the language that Jellinek had used to describe the individual symptoms that chronicle the descent towards chronic alcohol dependence.

Indeed, Glatt's Chart only retained three of Jellinek's original symptoms verbatim (Figure 4), 'surreptitious drinking (2)', 'unreasonable resentments (24)' and 'indefinable fears (38)'. Moreover, he replaced Jellinek's medically specific, and in some cases, archaic language with a plainer language. For example, Glatt combined the Jellinek symptoms of 'regular matutinal drinking (30)' and 'tremors (39)' to a single symptom, 'tremors and early morning drinks'; 'alcoholic palimpsests (1)', was simply amended to 'onset of memory blackouts'. However, some of Glatt's edits to many of Jellinek's symptoms were minor, e.g., 'marked ethical deterioration (32)' became 'moral deterioration'. It is noticeable that both, Jellinek's phases of alcohol dependency and Glatt's Chart, appear to have been influenced by the language of A.A., which is not surprising, as both researchers harvested their data entirely from the lived experiences of A.A. members.

For instance, one of the early recovery symptoms on the rehabilitation slope of Glatt's Chart, 'assisted in making personal stock taking', can reasonably be interpreted as a direct reference to step-

four of A.A. 12-step programme, 'Made a searching and fearless moral inventory of ourselves'. Additionally, there are references to peer-based recovery support, one of the central features of mutual-aid groups (e.g., 'meets recovered alcoholics well and happy, and new circle of stable friends'). However, it is possible that the evolution of the language may have been reciprocal. For example, the Jellinek symptom, 'geographic escape (22)', can often be heard in the individual narratives of its members at A.A. meetings†, in the form of 'geographical'; but then again, perhaps Jellinek had originally sourced the term from A.A. discourses, that were present in his data. Moreover, it could be argued that sourcing data solely from A.A. members, increases the probability of a single source bias. Again, this is understandable, because at the time of the 'chart's' creation, A.A. was the only mutual-aid organisation 'in town'. Fortunately, today, that is no longer the case, and there are a plethora of mutual-aid choices for people in recovery from alcohol use disorder (AUD), many of whom are likely to feel stigmatised (Alcohol Change UK, 2023), especially by the terminology that A.A. uses, e.g., alcoholic, alcoholism.

Glatt, one of the founders of the Medical Council on Alcoholism (MCA) and the National Council on Alcoholism (now Alcohol Change UK), was an influential figure in the field of alcoholism and addiction in the UK, and to a lesser degree in the USA. Indeed, Jellinek visited Pinel House twice in the fifties (British Journal of Addiction [BJA], 1983), as did Marty Mann, one of the first sober women members of A.A. and founder of the American National Council on Alcoholism (NCA), now the National Council on Alcoholism and Drug Dependence (NCADD). Glatt recalled meeting Jellinek on two other occasions, when Jellinek had invited him to contribute to an encyclopaedia of alcoholism that he had been compiling, unfortunately, Jellinek died before the project's completion. Although Glatt did not agree with all of Jellinek's hypotheses and thoughts in the context of alcohol harm, he "admired" Jellinek, "was very impressed by him", and found him to be "a very stimulating character" (BJA, p. 238, 1983). Unfortunately, there appears to be no record of any collaboration between the two regarding Jellineck's dependency phases and Glatt's Chart. Considering the two leading and influential addiction specialists had met on a number of occasions, it is a reasonable assumption that they must have discussed the mis-named 'Chart' at some point during their discourses, but of course, this is speculative.

Despite respected addiction scholars having acknowledged Glatt's contribution and invaluable additions to Jellineck's 'Phases of Alcohol Addiction' (e.g., Kelly, 2000; Ward et al., 2016), albeit downplaying Glatt's considerable role, a quick Google search highlights how the myth of the 'Jellinek

Curve' continues to be reinforced by many of the leading organisations in the field of recovery from addiction. For example, the 'Stages of Alcoholism' page on the website of the globally renowned recovery organisation, the Hazeldean Betty Ford Foundation (2019), no doubt unknowingly, misleadingly informs the reader that, "The Jellinek Curve, created by E. Morton Jellinek in the 1950s and later revised by British psychiatrist Max Glatt is a chart that describes the typical phases of alcoholism and recovery". Glatt did not 'revise' the 'Curve', he was solely responsible for its creation, as it appears today. Rather than pointing to the author's laziness in not taking the time to research the correct origin of the 'Curve', the above statement highlights the continuing mythologising of the 'Curve'.

In summary, the aim of this article has been to highlight a 70-year-old myth, concerning a milestone in the history of AUD and recovery science. Hopefully, by deconstructing a decades-old myth, and presenting the evidence to a professional audience in the field of alcohol harm, the process of crediting Max Glatt as the creator of the 'Curve' can begin in earnest, and thereby begin to put the record straight. That is, the misleadingly titled Jellinek Curve should bear the name of its creator and be referred to appropriately and correctly as the 'Glatt Chart', or even 'Glatt Curve', albeit with an acknowledgment to Jellinek for his contribution to the dependency phases.

*In 1980 there were estimated to be 35 NHS rehabilitation units in the UK, based on Glatt's Pinel House model of rehabilitation. Sadly today, that NHS 'free at the point of care' model of addiction rehabilitation is non-existent; there are no residential rehabilitation facilities within the NHS structure in the UK.

†The author, is an ex-patient of Pinel House, and has been in recovery and continuously abstinent since he entered Pinel House on 14th August 1990. He has attended thousands of A.A. meetings, in both the UK and US

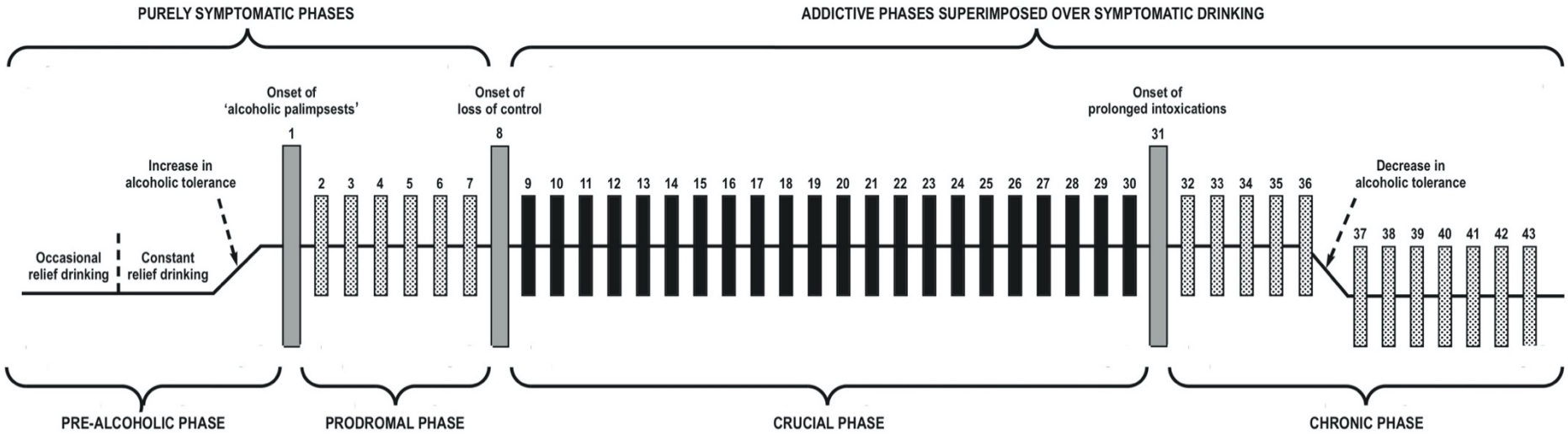


Figure 1. The Phases of Alcohol Addiction (Jellinek, 1952).

PRODROMAL[1] PHASE

1. Alcoholic palimpsests[2]
2. Surreptitious drinking
3. Preoccupation with alcohol
4. Avid drinking
5. Guilt feelings about his* drinking behaviour
6. Avoid reference to alcohol
7. Increased alcohol palimpsests

CRUCIAL PHASE

8. Loss of control
9. Rationalise his drinking behaviour
10. Social pressures
11. Grandiose behaviour
12. Marked aggressive behaviour
13. Persistent remorse
14. Periods of total abstinence

CRUCIAL PHASE (continued)

15. Changing the pattern of his drinking
16. Drop friends
17. Quit jobs
18. Behaviour becomes alcohol-centred
19. Loss of outside interests
20. A reinterpretation of personal relations
21. Marked self-pity
22. Geographic escape
23. Change in family habits
24. Unreasonable resentments
25. Protect his supply
26. Neglect of proper nutrition
27. First hospitalisation
28. Decrease of the sexual drive
29. Alcoholic jealousy
30. Regular matutinal[3] drinking

CHRONIC PHASE

31. Prolonged intoxications
32. Marked ethical deterioration
33. Impairment of thinking
34. Alcoholic psychoses
35. Drinks with persons far below his social level
36. Takes recourse to "technical products"[4]
37. Loss of alcohol tolerance
38. Indefinable fears
39. Tremors
40. Psychomotor inhibition
41. Drinking takes on an obsessive character
42. Vague religious desires develop
43. Rationalisation system fails

Notes on language

The language of both Jellinek and Glatt (refer to the 'time lag' box on Glatt's Chart) is gender specific, using the male pronoun only. Additionally, some of the terminology is medically archaic and needs explaining.

[1]*Prodromal* refers to the early symptoms of an illness/health problem before chronic symptoms manifest.

[2]*Alcoholic palimpsests* refers to alcohol induced memory loss, commonly referred to as 'alcoholic blackouts'.

[3]*Matutinal drinking* is morning drinking.

[4]In Jellinek's (1952) paper, *technical products*, refers to products containing ether alcohol, "such as bay rum or rubbing alcohol" (p. 682). In today's language, this translates, approximately, as aftershave and surgical spirits respectively.

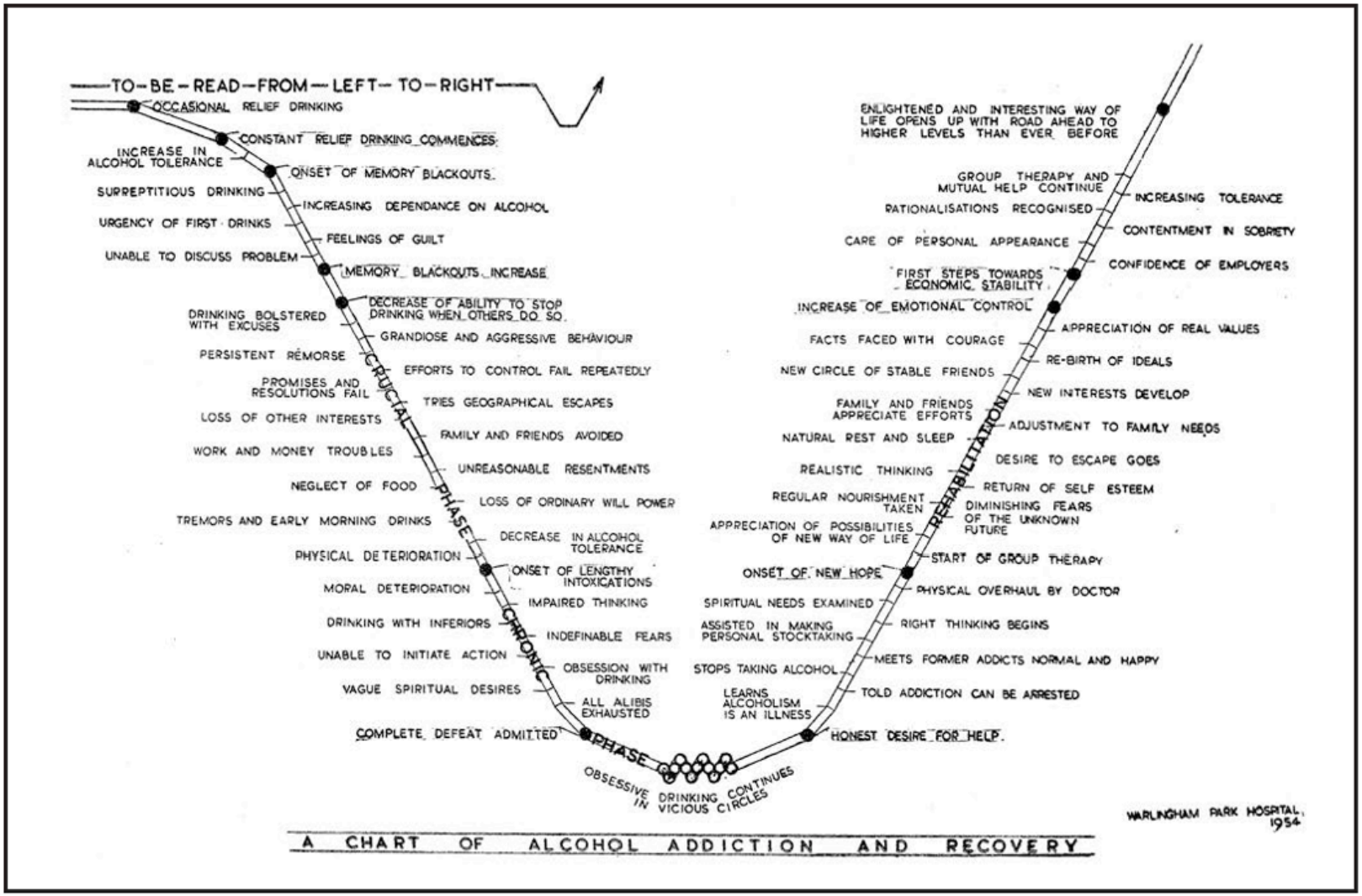


Figure 2. The original sketch of Glatt's Chart (1958).

N.B. The date in the bottom right/hand corner (1954) is four years prior to its 1958 publication date, and two years after Jellinek's 'phases' concept was published.

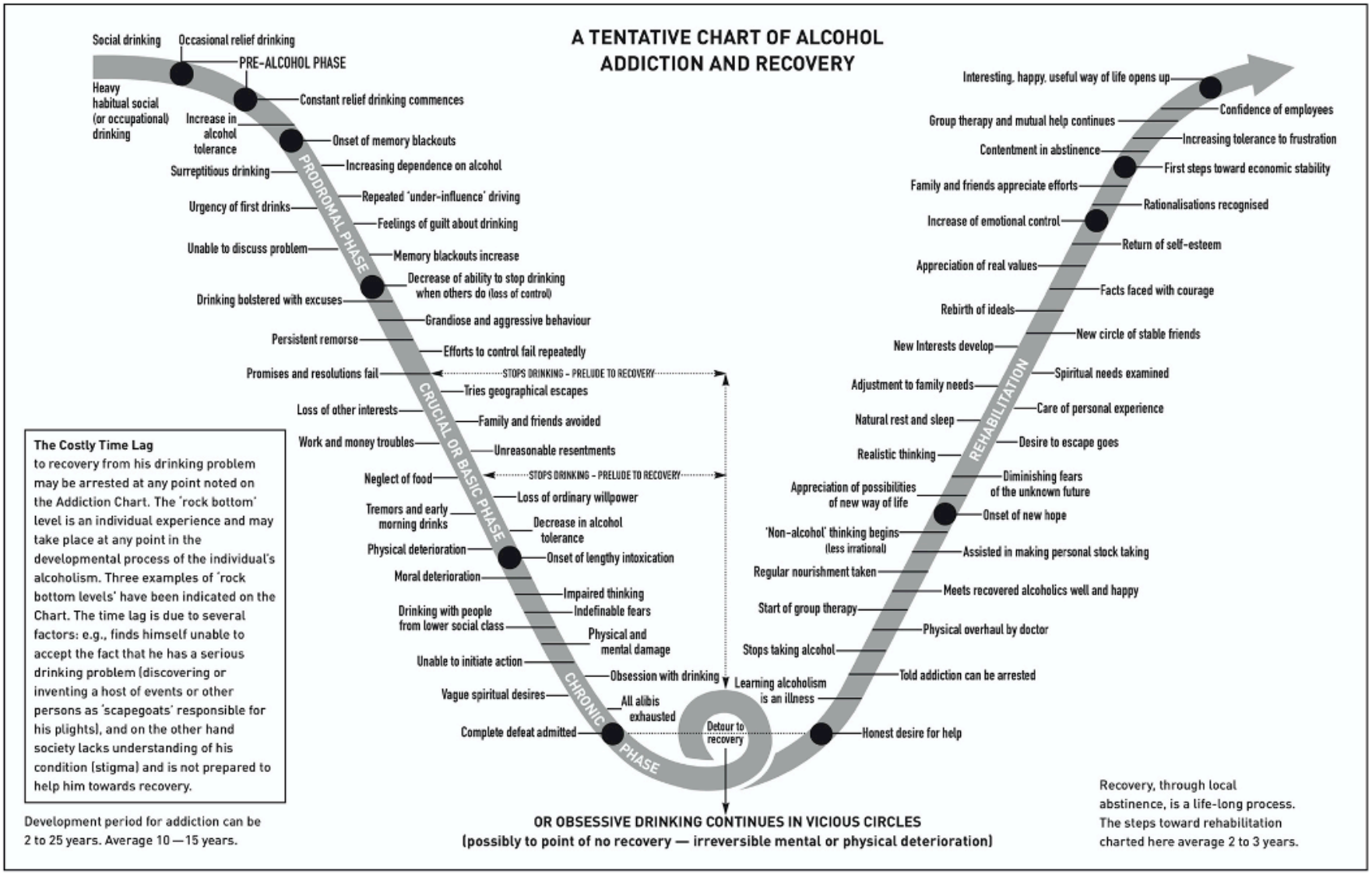


Figure 3. Glatt's Chart (1970).

GLATT'S EDIT

Jellinek's Original Items	Remaining Jellinek symptoms (verbatim) in Glatt's Chart	Glatt's
PRODROMAL PHASE	**PRODROMAL PHASE**	**PRE-ALCOHOL PHASE**
1. Alcoholic palimpsests	1. ~~Alcoholic palimpsests~~	1. Social drinking
2. Surreptitious drinking	2. Surreptitious drinking	2. Heavy habitual social (or occupational) drinking
3. Preoccupation with alcohol	3. ~~Preoccupation with alcohol~~	3. Occasional relief drinking
4. Avid drinking	4. ~~Avid drinking~~	**PRODROMAL PHASE**
5. Guilt feelings about his drinking behaviour	5. ~~Guilt feelings about his drinking behaviour~~	4. Constant relief drinking commences
6. Avoid reference to alcohol	6. ~~Avoid reference to alcohol~~	5. Increase in alcohol tolerance
7. Increased frequency of "alcoholic palimpsests"	7. ~~Increased frequency of "alcoholic palimpsests"~~	6. Onset of memory blackouts
CRUCIAL PHASE	**CRUCIAL PHASE**	7. Increasing dependence on alcohol
8. Loss of control	8. ~~Loss of control~~	8. Surreptitious drinking
9. Rationalise his drinking behaviour	9. ~~Rationalise his drinking behaviour~~	9. Repeated 'under-influence' driving
10. Social pressures	10. ~~Social pressures~~	10. Urgency of first drinks
11. Grandiose behaviour	11. ~~Grandiose behaviour~~	11. Feelings of guilt about drinking
12. Marked aggressive behaviour	12. ~~Marked aggressive behaviour~~	12. Unable to discuss problem
13. Persistent remorse	13. ~~Persistent remorse~~	13. Memory blackouts increase
14. Periods of total abstinence	14. ~~Periods of total abstinence~~	**CRUCIAL OR BASIC PHASE**
15. Changing the pattern of his drinking	15. ~~Changing the pattern of his drinking~~	14. Decrease of ability to stop drinking (loss of control)
16. Drop friends	16. ~~Drop friends~~	15. Drinking bolstered with excuses
17. Quit jobs	17. ~~Quit jobs~~	16. Grandiose and aggressive behaviour
18. Behaviour becomes alcohol-centred	18. ~~Behaviour becomes alcohol-centred~~	17. Persistent remorse
19. Loss of outside interests	19. ~~Loss of outside interests~~	18 Efforts to control fail repeatedly
20. A reinterpretation of personal relations	20. ~~A reinterpretation of personal relations~~	19. Promises and resolutions fail
21. Marked self-pity	21. ~~Marked self-pity~~	20. Tries geographical escapes
22. Geographic escape	22. ~~Geographic escape~~	21. Loss of other interests
23. Change in family habits	23. ~~Change in family habits~~	22. Family and friends avoided
24. Unreasonable resentments	24. Unreasonable resentments	23. Work and money troubles
25. Protect his supply	25. ~~Protect his supply~~	24. Unreasonable resentments
26. Neglect of proper nutrition	26. ~~Neglect of proper nutrition~~	25. Neglect of food
27. First hospitalisation	27. ~~First hospitalisation~~	26. Loss of ordinary willpower
28. Decrease of the sexual drive	28. ~~Decrease of the sexual drive~~	27. Tremors and early morning drinks
29. Alcoholic jealousy	29. ~~Alcoholic jealousy~~	28. Decrease in alcohol tolerance
30. Regular matutinal drinking	30. ~~Regular matutinal drinking~~	29. Physical deterioration
CHRONIC PHASE	**CHRONIC PHASE**	30. Onset of lengthy intoxication
31. Prolonged intoxications	31. ~~Prolonged intoxications~~	31. Moral deterioration
32. Marked ethical deterioration	32. ~~Marked ethical deterioration~~	32. Impaired thinking
33. Impairment of thinking	33. ~~Impairment of thinking~~	33. Indefinable fears
34. Alcoholic psychoses	34. ~~Alcoholic psychoses~~	34. Drinking with people from lower social class
35. Drinks with persons far below his social level	35. ~~Drinks with persons far below his social level~~	**CHRONIC PHASE**
36. Takes recourse to "technical products"	36. ~~Takes recourse to "technical products"~~	35. Physical and mental damage
37. Loss of alcohol tolerance	37. ~~Loss of alcohol tolerance~~	36. Unable to initiate action
38. Indefinable fears	38. Indefinable fears	37. Obsession with drinking
39. Tremors	39. ~~Tremors~~	38. Vague spiritual desires
40. Psychomotor inhibition	40. ~~Psychomotor inhibition~~	39. All alibis exhausted
41. Drinking takes on an obsessive character	41. ~~Drinking takes on an obsessive character~~	40. Complete defeat admitted
42. Vague religious desires develop	42. ~~Vague religious desires develop~~	
43. Rationalisation system fails	43. ~~Rationalisation system fails~~	

Figure 4. Glatt's Edit of Jellinek's Phases (1970).

References

Alcohol Change. (2023). *Challenging the stigma around alcohol*. https://alcoholchange.org.uk/alcohol-facts/fact-sheets/challenging-the-stigma-around-alcohol

British Journal of Addiction. (1983). Conversation with Max Glatt. *British Journal of Addiction*, *78*(3), 231-243. https://doi.org/10.1111/j.1360-0443.1983.tb02504.x

Glatt, M. M. (1955). A treatment centre for alcoholics in a public mental hospital: its establishment and its working. *British Journal of Addiction to Alcohol & Other Drugs*, *52*(1-2), 55-89. https://doi.org/10.1111/j.1360-0443.1955.tb04682.x

Glatt, M. M. (1958). Group therapy in alcoholism. *British Journal of Addiction, 54*(2), 133-148. https://doi.org/10.1111/j.1360-0443.1958.tb04266.x

Glatt, M. M. (1970). *The alcoholic and the help he needs. Part 2. Treatment.* Medical and Technical Publishing Co. Limited.

Glatt, M. M. (1991). Warlingham and Minnesota compared. *British Journal of Addiction*, *86*(1), 19-20. https://doi.org/10.1111/j.1360-0443.1991.tb02621.x

Hazeldean Betty Ford Foundation (2019, March 12). *Stages of Alcoholism. The Stages of Alcoholism: Recognizing the Signs*. https://www.hazeldenbettyford.org/articles/stages-of-alcoholism

Jellinek, E. M. (1946). Phases in the drinking history of alcoholics. Analysis of a survey conducted by the official organ of Alcoholics Anonymous (Memoirs of the Section of Studies on Alcohol). *Quarterly journal of studies on alcohol*, *7*(1), 1-88. https://doi.org/10.15288/QJSA.1946.7.1

Jellinek, E. M. (1952). Phases of alcoholic addiction. *Quarterly journal of studies on alcohol*, *13*(4), 673-684. https://doi.org/10.15288/qjsa.1952.13.673

Jellinek, E. M. (1960). *The disease concept of alcoholism*. Hillhouse Press. https://doi.org/10.1037/14090-000

Kelly, J. F. (2019). E. M. Jellinek's Disease Concept of Alcoholism. *Addiction*, *114*(3), 555–559. https://doi.org/10.1111/add.14400

Ward, J. H., Bejarano, W., Babor, T. F., & Allred, N. (2016). Re-introducing Bunky at 125: EM Jellinek's life and contributions to alcohol studies. *Journal of studies on alcohol and drugs*, *77*(3), 375-383. https://doi.org/10.15288/jsad.2016.77.375

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Table of **Recovery**
Personal Experiential Themes and Statements for Andy.

Key to themes:

1. Empathy born out of suffering.

2. Mental and emotional well-being.

3. Mutual-aid as an aspect of recovery capital.

4. A supportive family as an aspect of recovery capital.

Themes (& statements)	**Page & line**	**Quotes**
Empathy born out of suffering.		
Staying alive for the benefit of family viewed as purposeful.	15 367-368	*I pretend to myself, I'm staying alive for the benefit of my family, my mother particularly...*
Empathy towards others on the waiting list.	17 413-416	*I was concerned that, 'what if the guy in the next bed was twenty-five years old and had three kids'. Whereas, I'm 63, no children, no responsibilities, why would they choose to give me a liver over him and that was a concern of mine.*
Empathy towards the donor.	17 418-419	*But, there is some feeling that my good fortune has only come about because of somebody's bad fortune.*
Mental and emotional well-being.		
Minimising stress in recovery.	5 115-116	*...it's a job with very little responsibility, I don't take any of it home.*
Managing depression effectively in recovery.	6 131-132	*Yeah, I am. It's worked for me, pretty much permanently and, and it's very effective but there are side effects...*
Managing depression effectively in recovery.	6 134	*...it's still better than killing yourself.*
Acceptance of his state of being.	15 369-371	*I went into this surgery absolutely indifferent as to whether I survived it or not. Ehm, I'm not going to kill myself at that stage, but I really don't care if something else did.*
Acceptance of his state of being.	16 381-383	*I would, I'd say, you know, having the trans-plant's better than the alternative, but as I say, I really wasn't worried, if I didn't come around from the anaesthetic...*
Acceptance of his state of being.	16 386-387	*I don't dwell on it any longer, I just let it rumble on in the background, on the side lines. Like a distant thunderstorm.*
The ability to acknowledge emotions in sobriety.	17 427-429	*But, ehm, aside of that, yeah, there are, there are these mixed feelings, gratitude and feeling unworthy.*

Table of **Recovery**
Personal Experiential Themes and Statements for Andy.

Themes (with statements)	**Page & line**	**Key phrase**
The ability to acknowledge emotions in sobriety.	18 435-436	*I mean it's not as bad as it used to be, I'm, I'm finding I'm finding it easier to accept every day.*
The ability to acknowledge emotions in sobriety.	18 437-438	*Ehm, it's still not my liver, but I'm looking after it together with the other fella..*
The ability to acknowledge emotions in sobriety.	18 445-446	*I have to justify it to myself, I can't rely on something in the sky or fairy to do it for me.*
Mutual-aid as an aspect of recovery capital.		
The mutual-aid support of SMART recovery.	11 266-268	*I'd already been in SMART, following SMART Recovery, ehm for some time, I'd really been trying on and off to give up drink.*
Mutual-aid: connecting with fellow sufferers in recovery.	12 282-284	*Ehm, and there was a much broader spectrum of fellow sufferers, ehm, more my kind of people, you know.*
Mutual-aid: connecting with fellow sufferers in recovery.	12 296	*Powerful, welcoming...*
Mutual-aid: an effective intervention based on common suffering.	12 298-299	*I knew I was among friends or people who at least knew what I was going through.*
A supportive family as an aspect of recovery capital.		
The recovery capital of a supportive family.	14 329-331	*...she knows and I know we don't talk about what I bought with that, but she's not enabling me to drink, I don't need to, I don't want to.*
The recovery capital of a supportive family.	14 331-333	*Ehm, my sister is stalwart, ehm, I'd say she's must say she's really come up to bat for me...*
The recovery capital of a supportive family.	14 334-335	*I'm doing alright with support and, ehm, and my relationship with them.*
The recovery capital of a supportive family.	15 372-374	*Ehm, I'm not tremendously happy in my relationship with my partner, although she's been, she's been, sporadically, really, really lovely...*
The recovery capital of a supportive family.	15 377	*I could always count on her support.*

Link to view tables for all participants' 'RECOVERY' drinking PETs and Statements:

https://drive.google.com/drive/folders/16wdq1AXQj5VnJARcWDew8Tz5bSebHfh_?usp=drive_link

Survey Completion

0% 100%

Late-Onset Problem Drinking, and Meaning and Purpose in Life Study

UNIVERSITY OF DERBY

Welcome to the Study

Late-Onset Problem Drinking in Older Adults (50+): Psychosocial Characteristics and the Role of Meaning and Purpose in Life.

Thank you for your interest in taking part in this research, which requires you to complete a participant demographic/information form, and two questionnaires, that should take you no longer than ten minutes to complete.

To participate in the research you must be:

- 50 years-old or older

AND

- Either a *late-onset* drinker in recovery, (someone whose drinking became problematic approximately at around the age of 50 or later), OR an *early-onset* drinker in recovery (someone whose drinking became problematic earlier in life). There will be no reference to real names or identifying details of participants in the final thesis or any subsequent publications. You may withdraw from this research at any point up to ten days after participation.

You will be asked to create a unique participant code, made up of a combination of six letters/numbers. The code should be easy to remember, as it will enable you to withdraw your research easily if you so choose to.

Statement of Informed Consent

- I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- I understand that anonymous information collected about me may be used to support other research in the future and may be shared anonymously with other researchers.
- I understand that the anonymous information collected about me may be presented at academic conferences and used in reports and academic publications.
- I have read and understand the above statements and agree to take part in this study.

GDPR statement

A researcher will be collecting data from your participation in this study. This is the legal basis on which we are collecting your data. While this allows us to use your data, it also means we have obligations towards you to:

- not seek more information from you than that which is considered essential and necessary for the study.
- make sure that you are not identified by the any of the research data, by pseudonymising it, using ID codes.
- use your anonymised data only for the purposes of this study and for any relevant publications that arise from it.
- store data safely in password-protected databases to which only the named researchers have access.
- not keep your information for longer than is necessary (usually for seven years).
- safely destroy your data by shredding or permanently deleting them.

The University of Derby will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly. The researchers on the project with access to the data, are highly qualified and experienced and have been very careful to ensure the security of your data. The study was approved for its ethical standards by the University of Derby, College of Business, Law and Social Sciences Research Ethics Committee. However, in the unlikely event that you feel you need to make a complaint regarding the use of your information, you can email gdpr@derby.ac.uk or contact the University of Derby Data Protection Officer: Helen Selby, (01332) 591954. Alternatively, you may wish to call the Information Commissioner's Office, 0303 123 1113. Further information about the study can be obtained from the chief investigator: k.mcinereny1@unimail.derby.ac.uk. You can also telephone the University of Derby, 01332597981.

○ **Yes, I Consent**

Individual Ages of Participants

Age	*n*	%	Age	*n*	%	Age	*n*	%
50	16	4.2%	61	16	4.2%	72	3	0.8%
51	19	5.0%	62	15	3.9%	73	7	1.8%
52	17	4.5%	63	20	5.2%	74	4	1.0%
53	26	6.8%	64	16	4.2%	75	6	1.6%
54	21	5.5%	65	9	2.4%	76	4	1.0%
55	18	4.7%	66	8	2.1%	77	1	0.3%
56	18	4.7%	67	12	3.1%	78	1	0.3%
57	21	5.5%	68	10	2.6%	79	4	1.0%
58	26	6.8%	69	4	1.0%	80	1	0.3%
59	19	5.0%	70	9	2.4%	81	1	0.3%
60	17	4.5%	71	11	2.9%	86	1	0.3%

Recovery Organisations cited by Respondents as where they found Recovery and Locations of Respondents

Respondents' Main Recovery Organisations	No.	%
1 AA	174	45.66
2 NHS	13	3.43
3 No Organisation given	30	7.87
4 Rehab	11	2.88
5 Self (Natural Recovery)	29	7.61
6 SMART Recovery	17	4.46
7 UK Community Drug & Alcohol Services & NGOs	22	5.77
Total for Main Recovery Organisations	**296**	**77.68**
Other Recovery Organisations		
8 Alcohol Mastery (book)	1	0.27
9 Be Sober	1	0.27
10 Club Soda (online organisation)	6	1.57
11 Cocaine Anonymous (C.A.)	1	0.27
12 Community Drug and Alcohol Services (USA)	1	0.27
13 Counselling	4	1.05
14 Eight-Step Recovery (book)	1	0.27
15 Narcotics Anonymous (N.A.)	3	0.78
16 One Year No Beer (OYNB; online programme)	3	0.78
17 Recovery Dharma (meetings and online community)	5	1.31
18 Refuge Recovery (face-to-face and online meetings)	1	0.27
19 Religion	3	0.78
20 She Recovers (online programme and meetings)	1	0.27
21 Sober Curious (book)	2	0.52
22 Sober Punks (online community)	1	0.27
23 Soberful Life (online programme)	7	1.83
24 Sober School (online programme)	1	0.27
25 Sober Sis (online community)	4	1.05
26 Spiritual Help	1	0.27
27 Tempest (online programme)	1	0.27
28 The Alcohol Experiment (book)	2	0.52
29 The Luckiest Club (online programme)	1	0.27
30 The Naked Mind (book and online community)	7	1.83
31 The Other Side of Alcohol (book)	1	0.27
32 The Sinclair Method (online programme)	3	0.78
33 Tribe Sober (online community)	9	2.36
34 Unspecified Facebook and other online groups	12	3,14
35 Women for Sobriety (face-to-face and online meetings)	2	0.52
Total for Other Recovery Organisations	**85**	**22.32**
Overall Total	381	100.00

Respondents' Locations	No.	%
1 Australia	4	1.04
2 Bosnia	1	0.27
3 Canada	13	3.42
4 France	2	0.53
5 Germany	5	1.30
6 India	1	0.27
7 Ireland	4	1.00
8 Malaysia	1	0.27
9 Mexico	1	0.27
10		
11 Norway	1	0.27
12 Poland	1	0.27
13 South Africa	11	2.88
14 Turkey	1	0.27
15 Turkmenistan	1	0.27
16 UK	168	44.09
17 USA	162	42.53
18 Zimbabwe	1	0.27
Total	381	100.00

	Organisation	Years in Recovery	Onset type
1	AA	45	E
2	AA	24	E
3	AA	7	L
4	AA	24	E
5	AA	16	E
6	AA	35	E
7	AA	18	E
8	AA	18	E
9	AA	18	E
10	AA	25	E
11	AA	14	E
12	None given	35	E
13	AA	1	E
14	AA	9	E
15	AA	25	E
16	None given	1	L
17	AA	22	E
18	None given	8	E
19	AA	8	E
20	AA	18	E
21	AA	22	E
22	Other	4	L
23	AA	11	E
24	AA	13	E
25	Other	1	L
26	AA	36	E
27	AA	32	E
28	AA	38	E
29	AA	3	E
30	AA	16	E
31	AA	16	L
32	AA	36	E
33	AA	25	E
34	AA	9	E
35	AA	23	E
36	AA	43	E
37	AA	29	E
38	AA	22	E
39	AA	12	E
40	AA	15	E

	Organisation	Years in Recovery	Onset type
41	AA	15	E
42	AA	37	E
43	Other	1	L
44	NHS	1	L
45	NHS	1	E
46	AA	19	L
47	NHS	10	E
48	AA	29	E
49	SMART	1	E
50	Other	2	E
51	UK CDAS	1	E
52	NHS	1	E
53	AA	36	E
54	AA	31	E
55	UK CDAS	3	L
56	Other	1	L
57	Self	2	E
58	AA	2	L
59	Self	18	E
60	UK CDAS	5	E
61	None given	11	E
62	Other	7	L
63	UK CDAS	7	E
64	AA	13	E
65	AA	20	E
66	AA	3	E
67	UK CDAS	15	L
68	AA	15	E
69	UK CDAS	11	E
70	None given	7	E
71	UK CDAS	7	L
72	AA	29	E
73	AA	5	E
74	Other	5	E
75	AA	29	E
76	NHS	5	E
77	SMART	4	E
78	UK CDAS	9	E
79	AA	41	E
80	SMART	1	E

	Organisation	Years in Recovery	Onset type
81	UK CDAS	4	L
82	Rehab	8	L
83	Rehab	23	E
84	NHS	2	L
85	Other	1	E
86	Self	4	E
87	Other	1	E
88	Other	1	L
89	Other	3	E
90	Self	3	L
91	Other	1	L
92	Other	1	E
93	Other	1	E
94	Other	2	L
95	Other	1	L
96	None given	10	E
97	Self	4	E
98	Other	2	E
99	Self	2	E
100	Other	1	E
101	AA	21	E
102	AA	23	E
103	AA	30	E
104	NHS	20	L
105	Self	2	L
106	UK CDAS	2	E
107	AA	36	E
108	AA	1	L
109	AA	9	L
110	AA	46	E
111	AA	26	E
112	NHS	2	L
113	AA	5	E
114	Self	1	E
115	SMART	3	E
116	UK CDAS	12	E
117	SMART	10	E
118	AA	7	L
119	UK CDAS	1	L
120	Other	2	L

	Organisation	Years in Recovery	Onset type
121	Other	1	L
122	AA	4	E
123	Other	18	L
124	NHS	2	E
125	AA	2	E
126	UK CDAS	3	L
127	None given	1	L
128	UK CDAS	2	L
129	None given	1	L
130	Other	1	E
131	Rehab	3	E
132	Rehab	1	L
133	AA	1	E
134	AA	3	L
135	NHS	1	E
136	Other	1	E
137	Other	1	E
138	Other	2	L
139	UK CDAS	6	E
140	AA	3	L
141	AA	1	E
142	Other	1	E
143	SMART	3	L
144	AA	5	L
145	AA	31	E
146	None given	1	E
147	AA	1	E
148	None given	3	E
149	Other	13	E
150	AA	1	E
151	AA	4	L
152	AA	4	E
153	None given	1	E
154	SMART	1	L
155	None given	3	E
156	Other	15	E
157	Other	1	E
158	AA	3	L
159	Other	7	E
160	Rehab	1	E

	Organisation	Years in Recovery	Onset type
161	AA	21	E
162	AA	1	L
163	AA	5	E
164	AA	13	E
165	AA	35	E
166	None given	1	L
167	Other	1	E
168	Other	1	E
169	8	4	E
170	SMART	9	E
171	AA	3	L
172	AA	9	E
173	Other	2	E
174	UK CDAS	1	L
175	UK CDAS	2	E
176	AA	1	L
177	UK CDAS	1	L
178	Self	1	E
179	AA	1	L
180	AA	4	E
181	Other	1	L
182	AA	10	E
183	Other	5	L
184	Other	6	L
185	AA	2	L
186	NHS	1	L
187	Self	3	L
188	AA	12	E
189	Other	5	E
190	AA	1	E
191	Other	1	L
192	None given	4	L
193	Rehab	1	L
194	AA	9	L
195	Other	1	L
196	Other	1	E
197	Other	1	E
198	Rehab	2	L
199	Other	2	L
200	AA	4	E

	Organisation	Years in Recovery	Onset type
201	None given	1	L
202	Other	2	L
203	Other	2	E
204	AA	9	L
205	Self	2	L
206	Self	1	E
207	Self	2	L
208	AA	5	E
209	Other	3	L
210	Other	3	E
211	SMART	1	L
212	AA	1	E
213	Other	1	L
214	Rehab	1	E
215	UK CDAS	1	E
216	Other	1	L
217	Other	1	L
218	AA	6	E
219	AA	22	E
220	Self	1	E
221	Other	1	L
222	Self	5	E
223	AA	39	E
224	AA	6	L
225	AA	3	L
226	AA	1	E
227	Other	1	L
228	Self	8	L
229	AA	16	E
230	SMART	4	E
231	Other	2	E
232	SMART	11	E
233	None given	1	E
234	AA	33	E
235	AA	3	L
236	Other	4	L
237	UK CDAS	6	L
238	Self	1	L
239	Other	1	L
240	Other	4	E

	Organisation	Years in Recovery	Onset type
241	None given	1	E
242	None given	1	E
243	Other	1	E
244	UK CDAS	5	E
245	None given	1	E
246	AA	3	E
247	AA	4	E
248	NHS	3	E
249	Other	1	L
250	AA	1	L
251	Other	4	E
252	AA	18	E
253	Other	3	L
254	AA	8	E
255	SMART	2	L
256	None given	1	L
257	AA	18	E
258	AA	41	E
259	SMART	3	L
260	AA	9	E
261	Other	1	E
262	Other	3	E
263	Other	3	L
264	AA	3	L
265	AA	1	E
266	Self	35	E
267	None given	3	L
268	AA	16	E
269	AA	13	E
270	AA	37	E
271	SMART	10	E
272	AA	1	E
273	Other	5	E
274	Other	1	L
275	Other	4	E
276	AA	29	E
277	AA	35	E
278	Other	1	E
279	AA	6	E
280	AA	4	L

	Organisation	Years in Recovery	Onset type
281	AA	1	L
282	Other	2	L
283	None given	1	E
284	Self	1	L
285	Other	1	L
286	Other	1	E
287	Self	3	L
288	AA	10	E
289	AA	7	E
290	Other	2	E
291	Other	30	E
292	AA	1	L
293	SMART	1	L
294	Other	24	E
295	AA	9	E
296	AA	8	L
297	Other	1	L
298	None given	1	L
299	Other	3	E
300	Self	4	E
301	AA	2	E
302	AA	1	L
303	AA	18	E
304	AA	36	E
305	AA	37	E
306	AA	38	E
307	AA	1	L
308	AA	34	E
309	AA	35	E
310	AA	32	E
311	AA	37	E
312	AA	30	E
313	AA	27	E
314	Rehab	1	L
315	AA	28	E
316	AA	14	E
317	AA	10	E
318	AA	30	E
319	AA	1	L
320	AA	33	E

	Organisation	Years in Recovery	Onset type
321	AA	52	E
322	AA	7	L
323	AA	14	L
324	AA	44	E
325	AA	2	E
326	AA	13	E
327	AA	1	E
328	Self	1	E
329	AA	31	E
330	AA	10	L
331	AA	3	L
332	AA	9	L
333	Other	1	L
334	AA	39	E
335	AA	3	L
336	Self	2	E
337	AA	41	E
338	AA	13	E
339	None given	1	E
340	AA	2	E
341	Other	1	E
342	AA	37	E
343	Other	2	L
344	Other	3	L
345	AA	32	E
346	AA	12	L
347	SMART	1	E
348	AA	26	E
349	Self	1	E
350	Other	1	L
351	Self	1	L
352	AA	4	E
353	Other	2	E
354	Self	1	L
355	AA	28	E
356	Other	1	L
357	AA	34	E
358	AA	7	E
359	AA	35	E
360	AA	11	E

	Organisation	Years in Recovery	Onset type
361	Other	1	L
362	Self	1	L
363	Other	1	E
364	AA	2	E
365	AA	2	E
366	Rehab	3	E
367	SMART	1	L
368	Other	1	E
369	Other	3	E
360	Self	1	E
371	Other	1	E
372	Other	1	L
373	Other	2	E
374	Other	1	L
375	Self	11	E
376	Other	1	L
377	Other	2	L
378	SMART	1	E
379	Other	1	L
380	UK CDAS	1	E
381	AA	4	E

EARLY-ONSET (249)		
Length of sobriety/ Organisation	*n*	%
20-52 years	69	28%
15-19 years	16	6%
10-14 years	25	10%
Total	110	44%
Total above in AA	93	37%
1-9 years	139	56%
AA	40	16%

LATE-ONSET (132)		
Length of sobriety/ Organisation	*n*	%
10-20 years	8	6%
4-9 years	24	18%
1-3 years	100	76%
AA	37	28%

Origins of A.A.'s Twelfth Step

In June 1935, A.A.'s founder, Bill Wilson, had been sober (in recovery) for six months. He had spent much of that time talking to and trying to help other problematic drinkers in New York, where he lived; a few of these stopped drinking for short periods but always relapsed. That none of the problem drinkers (peers) he approached had managed to remain sober caused Wilson great despondency. However, his wife, Lois[1], wisely pointed out to Wilson, that he was missing the point, which was that simply making the effort to help fellow problem drinkers (peer-based recovery support) was enough; it had reinforced Wilson's own sobriety (abstinence self-efficacy) and, importantly, had given him a life purpose. For Wilson, this was a lightbulb moment. Shortly afterwards, Wilson found himself alone in Akron, Ohio, depressed and psychologically and emotionally vulnerable, after a failed business venture. At one end of the hotel lobby, the bar was beginning to appeal to Wilson. He remembered, however, what had worked previously for him (i.e., talking to another problem drinker). At the opposite end of the hotel lobby was a telephone kiosk and using a church telephone directory[2]. Wilson randomly called and spoke to a number of ministers, enquiring if they could put him in touch with another problematic drinker. Eventually, he spoke to someone, who knew of a problem drinker he should contact; that was Bob Smith, who was to become, arguably[3], A.A.'s co-founder, and a meeting was arranged for the next day. Even though he didn't meet Smith until the following day, Wilson's experiences of the previous six months, were enough to motivate him not to drink that evening; simply making the effort to help another problem drinker was enough to reinforce Wilson's abstinence self-efficacy and provide him with a purpose in life, until the next day, when he met his peer, Bob Smith.

Endnotes

1. Lois Wilson founded A.A.'s sister fellowship, Al-Anon Family Groups, for family and friends of problem drinkers.
2. At the time of his failed business trip, in the Mayflower hotel, Akron, Wilson had been attending meetings of the *Oxford Group*, an evangelical Christian movement. Therefore, his decision to reach out for help through a church directory would have been natural behaviour for him at the time. After many calls, Wilson was eventually put in touch with an *Oxford Group* member, who arranged for him to meet Dr. Bob Smith the following day (Stepping Stones, 2021).
3. Since its foundation on 10th June 1935, Dr. Bob Smith, has been regarded as A.A.'s co-founder, along with Bill Wilson. However, William Schaberg (2019), who spent eleven years researching the formative years of A.A., challenges a number of deeply embedded A.A. myths. One of these being Smith's mythical status as A.A.'s co-founder. According to Schaberg (2019), Wilson is the sole founder of A.A. Schaberg's (2019) research clearly shows that Wilson's primary collaborator on the formation of A.A. including the main text of A.A., *Alcoholics Anonymous*, commonly referred to as the 'Big Book', and the framework for A.A.'s 12-step programme, was Henry (Hank) Parkhurst. Unfortunately, shortly after the publication of the Big Book in 1939, Parkhurst relapsed, and his considerable contribution to A.A.'s formative years, appears to have been erased from A.A. history.

References

Schaberg, W. H. (2019). *Writing the Big Book: The creation of AA*. Central Recovery Press.

Stepping Stones. (2021). Stepping Stones. Historic Home of Bill and Lois Wilson: *Bills Story*. https://www.steppingstones.org/about/the-wilsons/bills-story/