Alcohol in later life: A qualitative study on alcohol use among older people in New Zealand

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ABSTRACT

Alcohol use among older people in New Zealand has been identified as a growing issue and contributes significantly to the economic burden on society. Identification of reasons for older people's alcohol use and why they drink in such a way is essential to provide understanding of their drinking behaviours. This study used a social constructionist framework to explore how older people talked about their alcohol consumption. The study aimed to understand why older people drink alcohol by examining discourses they had drawn on to construct their behaviour and subject positions offered by these discourses.

Data analysed in this study were collected as part of the New Zealand Longitudinal Study on Aging (NZLSA). The sample included 18 individuals aged from 53 to 74 years, who were selected on the basis of their reported drinking status (light to heavy drinker), as identified with the Alcohol Use Disorder Identification Test-C in the 2010 NZLSA survey. Data was analysed using a discourse analysis on the transcribed text. Participants talked about their alcohol use as being an integral part of their social lives and something they do for sociability, to enhance social situation and to help them relax and unwind. They consistently drew on the positive constructions of alcohol use and positioned themselves as good, healthy and controlled drinkers. Participants did not identify with harmful alcohol use. They constructed problem drinking as being younger people's behaviour and a health issue for heavy and excessive drinkers.

Findings indicate that the positive aspects of health messages are taken up enthusiastically to support the positive constructions of alcohol use, as evident in the participants' use of the public discourse on benefits of drinking in moderation. However, negative health messages, such as ones given with medications, are often ignored or seen as outweighed by alcohol desirability. Findings of this study add to knowledge of alcohol use in this population and may be used to support future health promotion initiatives that aim to reduce harmful alcohol use in this population.

Dedication

Dedicated to my children Iva and Luka Aitken.

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Contents:

CHAPTER 1

INTRODUCTION

1.1. Alcohol as a commodity

Alcohol has been widely used around the world for thousands of years. Alcohol is produced from water and sugar found in ripe fruits, grains and vegetables through the process of fermentation. Beer and wine were initially produced and the discovery of distillation around the 8th century allowed for beverages with a higher concentration of alcohol such as gin and rum. Throughout history, some alcoholic beverages, such as beer, were valued as a source of nutrition. Because it was easy to store, beer was used in times of scarcity. However, currently produced alcoholic beverages, being more refined, are low in nutrition. Many alcoholic beverages are a good source of energy, but they provide 'empty calories' (Youngerman, Dingwell, Golden & Peterson, 2010). These beverages do not contain a significant quantity of vitamins or protein and are not considered as beneficial for human dietary needs (Babor et al., 2010).

People consume alcohol for different reasons. Alcohol is used as a medicine, for religious and social purposes, as well as for pleasure and facilitating relaxation. People drink alcohol during social events, such as births and weddings, and during religious gatherings, such as bar mitzvahs. Alcohol is used to induce trance-like states in Brazilian-African rituals and as a means to relieve anxiety. In today's societies people mainly drink for social reasons, enjoyment and hospitality, but also for intoxication (Babor et al., 2010; Myers & Isralowitz, 2011).

Alcohol is associated with a diverse range of positive and negative outcomes and feelings. It has been identified as a stimulant and depressant, as well as food and poison. Positive effects of alcohol in facilitating social interaction and relaxation should not overshadow negative effects that this substance may cause to our health and wellbeing. Alcohol slows down many central nervous system functions, such as judgment, reasoning,

perception and memory. It is also an irritant and toxin for organs in our body. Alcohol can cause cancer, cell damage and abnormalities in an unborn child, it is also an addictive substance causing dependency (Health Promotion Agency [HPA], 2013; Korhonen, 2004).

Alcohol became a popular commodity during globalisation towards the end of the 20th century that was effectively spread to Western and non-Western cultures across the world (Hames, 2012). Global advertising promoted various types of alcohol and domestic, as well as international, production increased to meet the growing demand. In regards to New Zealand, alcohol consumption significantly increased after the end of World War Two and reached its peak at 12 litres of pure alcohol per capita per annum in 1978 (New Zealand Law Commission, 2009). This was the time that baby-boomers, the generations raised after World War Two, experienced their late teens and 20s. Baby-boomers, compared to previous generations, introduced liberal views on alcohol consumption in this country. They enjoyed increased levels of disposable wealth and leisure time, which also influenced their drinking habits (McEwan, Campbell, Lyons & Swain, 2013).

Liquor liberalisation in New Zealand was achieved through the Sale of Liquor Act 1989 allowing for the wider sale of alcohol through easier access to liquor licences and availability of alcohol in local supermarkets. The 1999 Act legitimised this liberalisation further by lowering the minimum purchase age from 20 to 18 years. During this period alcohol consumption dropped to a low of 8.5 litres. In recent years consumption has increased to 9.6 litres of pure alcohol per capita (McEwan et al., 2013). This is in line with alcohol consumption in Australia and USA. However, as the Alcohol Advisory Council (ALAC, 2006) indicates, it is not how much we drink per capita through the year, but how we drink alcohol that matters. The importance of the way we drink is outlined by Cagney (2006) who suggests that alcohol related problems are associated with the pattern of drinking, rather than average consumption of alcohol. For instance, binge drinking, which refers to drinking larger quantities of alcohol per occasion, is associated with a greater frequency of drinking problems, such as violence, accidents and diseases, than moderate drinking.

1.2. Adverse health effects and the societal burden

Alcohol use is causing many adverse health effects to people and contributes significantly to the economic burden to societies. International data suggests that an increase of alcohol consumption in societies is associated with increased rates of alcohol abuse, mortality and an increase in rates of people suffering from heart, liver and other chronic conditions (Hames, 2012; Balsa, Homer, Fleming & French, 2008; Wilson et al., 2013; Immonen, Valvane & Pitkäla̋, 2011). Rehm et al. (2009) indicates that alcohol use contributes four percent of total mortality and between four and five percent of disability-adjusted life-years, and therefore is considered to be one of the largest avoidable risk factors. Disability-adjusted life-years are a time-based measure that combines years of life lost due to premature mortality and years of life lost in full health (Connor, Kydd, Shield & Rhem, 2013).

Alcohol has been identified as the most commonly used recreational drug in New Zealand (Field & Casswell, 1999; ALAC, 2006). However, its use has been disproportionately distributed across populations. Evidence suggests that quantity of alcohol use declines with age, but that older New Zealanders drink more frequently than their younger counterparts (Ministry of Health [MoH], 2013). Adverse health effects caused by alcohol are documented in a recent report, which identified that in the year 2007 there were 802 deaths of New Zealanders under 80 years of age that were attributable to drinking alcohol, which is 5.4 percent of all deaths in this age group (Connor et al., 2013). Causes of death varied, but overall 43 percent were due to injuries, 30 percent were due to cancer and 27 percent due to other chronic conditions. In regards to gender, men were twice as likely to die due to alcohol related reasons compared to women. Evidence suggests that internationally men in general use and abuse alcohol more than women (Babor et al., 2010; Youngerman et al., 2010; Rhem et al., 2009), which may explain the above mentioned findings.

An economic burden caused by alcohol in societies is evident. The costs associated with harmful alcohol use contribute to more than one percent of the gross national product in high-income and middle-income

countries (Rhem et al., 2009). An estimated cost of harmful alcohol use in New Zealand in 2005/06 was $4,437 million of diverted resources and lost welfare (Slack, Nana, Webster, Stoke & Wu, 2009). The same report identified that the net health care cost related to alcohol for the same period was $290 million. Alcohol does not only affect the drinker. Alcohol can also affect the health of others and cause social harm to both the drinker and others, which increases the overall cost associated with alcohol use. It is estimated that 50 percent of this cost may be potentially avoided with interventions targeting reduction in harmful use (Rehm et al., 2009).

In spite of the wealth of evidence on its adverse effects, international research reports some positive effects of alcohol on human health. For instance, low to moderate alcohol use is found to be beneficial for our cognitive functioning (e.g., Truelsen, Thurdium, & Gronbaek, 2002; Lang, Wallace, Huppert & Melzer, 2007), as well as prevention of cardio vascular diseases (Abramson, Williams, Krumholz, & Vaccarino, 2001). Evidence also suggests that drinking in moderation improves our overall well-being. For example, Byles, Young, Furuya and Parkinson (2006) in their study found that low to moderate intake of alcohol is associated with lower risk of death and better health-related quality of life in older women compared to non-drinkers. However, Rehm et al. (2009) argues that these inconclusive findings are outweighed by the detrimental effects of alcohol on diseases and injury.

1.3. Alcohol and older people

Defining older people and old age is problematic (Ward, Barnes & Gahagan, 2011). The term old age captures different age groups and generations. Currently there is no standard numerical criteria for old age, but the United Nations indicate that people who are 60 years and older are considered to be older people (World Health Organization, 2014). Therefore, for the purpose of this project, older people refers to individuals who are 60 years of age and older. International data indicates that, compared to earlier generations, older people, on average, experience better

health, higher levels of income and better intellectual capital (United Nations Department of Economic Social Affairs, 2013).

Older people present an at-risk group when it comes to alcohol use (Myer & Isralowitz, 2011; Sorroco & Ferrell, 2006). The aging body experiences diverse physiological changes and reduced tolerance to alcohol compared to their younger counterparts (Barns, Abel & Ernst, 1980). Prevalence of co-morbid health conditions in this population group and negative interaction of alcohol with medications are potential issues related to drinking in later life. Alcohol in older people is associated with injuries and falls (Johnston & McGovern, 2004), the risk of motor vehicle accidents (Sorrock, Chen, Gonzalgo & Baker, 2006) and pedestrian fatalities (Holubowycz, 1995). Moderate and heavy alcohol use among people over 65 increases 16 times the likelihood of suicide, compared to people who are not drinking in this age group, which is associated with depressive disorders (Grabbe, Demi, Camann & Potter, 1997). Older people also experience different lifestyles influenced by retirement, lower levels of income and mobility, and generally reduced social networks compared to younger population groups. These are all factors associated with potential alcohol misuse.

Evidence suggests that alcohol use and alcohol related problems have increased among older people in the USA, Australia and many European countries (Hallgren, Hőgberg & Andreásson, 2010; Hunter, Lubman & Barrat, 2011; Sacco, Kuerbis, Goge & Bucholz, 2012). A similar trend is identified in New Zealand (Khan, Davis, Wilkinson, Sellman & Graham, 2002). Alcohol in the older population has been considered an 'invisible epidemic' (Sorroco & Ferrell, 2006), indicating that older people lack visibility as they are likely to drink in the privacy of their homes. However, policy and media attention is mainly focused on young 'binge' drinkers, because visibility of their drinking behaviours is identified as a matter of concern.

Literature identified three major patterns in alcohol use among older people. The early onset drinkers are those who drink for many years and continue to do so as they age (Plebani, Oslin & Libson, 2013). The early onset drinkers may also increase their drinking due to external factors, such

as loss of employment or a spouse who may have controlled their drinking previously. Late onset drinkers usually begin their alcohol use in response to a specific stressor, such as the death of a spouse. Intermittent or binge drinkers are people who use alcohol occasionally and sometimes to excess (Oliver, 2013). International data indicates that older heavy drinkers, in general, reduce their drinking with age (Fillmore et al., 1991; Myer & Isralowitz, 2011). However, this pattern appears to be gender dependent. Breslow, Faden and Smothers (2003) in their study found that American men are likely to reduce their heavy drinking with age, while their moderate drinking remains relatively stable. The same study found that older American women are likely to decrease their moderate drinking, but they continue with heavy drinking as they age. Other studies provide mixed results indicating that alcohol use in later life is a complex behaviour, which is mediated by many factors, such as sociodemographic characteristics, social environment and health status (Moos, Schutte, Brennan & Moss, 2010).

Reasons for alcohol use among older people are diverse. For instance, Ward, Barnes and Gahagan (2011) found that alcohol for some older people in their United Kingdom (UK) sample was associated with pleasurable social interaction, while others reported drinking to fill an absence in their lives. Khan, Wilkinson and Keeling (2006) in their study identified that older New Zealanders consumed alcohol for social reasons, before and with meals, and for relaxation. In contrast, a Finnish study found that older people explain their alcohol use as a treatment for health problems (Aira, Hartikainen & Sulkava, 2008). Tolvanen (1998) in her study on contextual meanings of alcohol found that older Finnish people (60–89 years) described their alcohol use in the context of their everyday life, but they did not see it as a question related to ageing. Alcohol is seen as a part of everyday life, as documented by Haarni and Hautamäki (2010) in their Finnish study of 31 former or present alcohol consumers aged 60 to 75 years.

Alcohol use among older people in New Zealand is common. The New Zealand Health Survey 2011-2012 found that around 82 percent of 55 to 64-year-olds, 79 percent of 65 to 74-year-olds and 66 percent of people

aged 75 and older drink alcohol (MoH, 2013). While many older people may use alcohol in moderation, some may experience drinking problems. The MoH study (2013) identified that 530,000, which is one in five New Zealanders, drink hazardously. Hazardous drinking refers to a drinking pattern that is associated with a high risk of harm to a drinker's physical and mental health and potential alcohol related harmful social effects. In regards to the age groups and gender, the study found that 20 percent of males and close to 10 percent of females aged 45 to 54, and approximately 17 percent of males and five percent of females aged between 55 and 64 have hazardous drinking patterns.

While the above mentioned evidence provides some insight into potentially problematic alcohol use in older New Zealanders, it is possible that these findings are underestimated and underreported. For instance, Wilson et al. (2013) in their UK study found that drinking in the older population is subject to stigma and that older people may feel pressured to present their drinking as moderate and appropriate. This is particularly found to be the case with older women, as documented by Emslie, Hunt and Lyons (2011) in their study on drinking attitudes among Scottish participants in their mid-life. Alcohol problems in older people may also be undetected and misinterpreted as a symptom related to old age and its associated illnesses.

The aging population is steadily increasing and people who are 60 years and older constitute the fastest growing population worldwide. The United Nations Department of Economic and Social Affairs (2013) estimates that globally the number of older persons aged 60 years and over is expected to more than double, from 841 million people in 2013 to more than 2 billion in 2050. Cohorts of baby-boomers, who are reaching their retirement age, have alcohol-related habits that are not as conservative and are considered more socially acceptable, compared to previous generations. ALAC (2006) indicates that alcohol in New Zealand is not considered to be a drug and it is accepted as part of everyday consumer behaviour. Similar findings are recorded by Tolvanen (1998), who in her Finnish study identified that older people consider smoking to be a health hazard and subject to social disapproval, while use of alcohol is not. Taking into

account current evidence and outlined patterns, the aging population with their current drinking behaviours may be in danger of developing alcohol related disorders, such as alcohol dependency and abuse, as well as suffering from further health complications.

1.4. Alcohol and the aging body

The effects of alcohol on the human body depend on the concentration of alcohol in the bloodstream and how quickly it is absorbed from the stomach into the blood, distributed within the body and excreted from the body. Blood alcohol concentration (BAC) depends on the proportion of fat and water in the body and differs in women and men. For instance, women in general have a higher amount of body fat and smaller body mass, even when they are the same body weight as men (Myer & Isralowitz, 2011). Therefore, women may reach a higher BAC compared to men with the same quantity of alcohol consumed.

The body's ability to metabolize alcohol quickly tend to decrease with age (Babor et al., 2010). Older people experience increased sensitivity to alcohol due to a decreased body water content and increased fat content associated with an aging body. Taking into account that alcohol is more soluble in water, older people have higher BAC for any consumed dose (Dufour & Fuller, 1995; Myer & Isralowitz, 2011). Older women are particularly sensitive to alcohol due to these physiological differences compared to men. Further health complications in older drinkers may be caused by alcohol interacting with medications, which are largely used in this population group. Once combined with psychosocial factors, such as loneliness, transition into retirement, bereavement and other stressors associated with older age, alcohol may have serious adverse effects for older people.

The current guidelines for low-risk alcohol use for adults in New Zealand (including young adults aged 18-24 years) suggest that women should drink no more than two standard drinks a day and no more than 10 standard drinks a week (ALAC, 2014). According to the same guidelines,

men should drink no more than three standard drinks a day and no more than 15 standard drinks a week. Both men and women are suggested to have at least two alcohol free days every week. However, there are no strict guidelines for alcohol use among older people. Suggestions worldwide indicate that this population should drink fewer units than imposed in the standard set for the general adult population (ALAC, 2014; Agewell, 2014).

1.5. Positive effects of alcohol

In general, people do not consume alcohol to intentionally get injured or ill. Rather, they drink because it makes them feel good (Wright, 2013). Recent evidence suggests that alcohol consumed by either heavy drinkers or non-heavy drinkers leads to the release of endorphins (a 'feeling good' chemical) in areas of the brain that produce feelings of pleasure and reward (Mitchell et al., 2012). These feelings are dependent on a BAC level in the body. University of Rochester (2013) indicates that BAC of between 0.03 percent and 0.059 percent is experienced as the 'pleasure zone', which can be achieved and maintained by consuming approximately one standard drink per hour. Amounts of alcohol that exceed the outlined BAC are likely to produce depressive and less pleasurable effects in people (Wright, 2013).

International evidence suggests that moderate alcohol consumption may be beneficial for our health. For instance, Brodsky and Morristown (1999) found that drinking in moderation is associated with increased social interaction, morale and improved orientation and general functioning. They indicate that this may further cause stress reduction and mood enhancement in relevant individuals, as well as to improve overall cognitive functioning. Evidence also suggests that drinking a low to moderate amount of alcohol is beneficial for older people's cognitive functioning and it is a protective against dementia (Bond et al., 2005; Truelsen et al., 2002; Mukamal et al., 2003). Some studies found this effect to be particularly shown in women (i.e., Elias, Elias, D'Agostino, Silbershatz, & Wolf, 1999). However, these effects are identified as beneficial for specific areas of cognitive functioning. For instance, Lang et al. (2007) found that moderate alcohol

intake has an effect on recall and numerical reasoning, but no significant association was found with orientation.

International data indicates that low to moderate alcohol use is beneficial for the prevention of cardiovascular diseases, such as coronary heart disease, heart failure and myocardial infarction in people (Abramson et al., 2001; Mukamal et al., 2003; Rehm, Gmeal, Sempos & Trevisan, (2002). Evidence on the benefits of light to moderate drinking on cardiovascular diseases in older people was initially criticised as being biased due to a potential avoidance of alcohol in relation to pre-existing conditions (Frishman, 2013). It was suggested that people who drink in moderation are the ones whose health permits them to do so. However, these positive effects of moderate drinking are now accepted (Klatsky, 2004), but they lack an explanation of mechanisms that underlie this relationship.

Evidence suggests that drinking in moderation is particularly beneficial for women's health. For instance, moderate consumption of wine is found to be beneficial for bone density in older American woman (Mukamal, Robbins, Cauley, Kern & Siscovick, 2007). A recent study by Di Giuseppe and colleagues (2012) observed that moderate drinking is associated with a reduced risk of rheumatoid arthritis in Swedish older women. Sun et al. (2011) in their study found that regular, moderate consumption of alcohol at midlife may be related to a modest increase in overall health among American women who survive to older ages. They found that, compared to non-drinkers, women who consumed between one-third and one drink per day during their midlife had about a 20 percent higher chance of successful ageing. Gavaler and colleagues (1991) in their study of postmenopausal women of several nationalities found that moderate alcohol consumption increases blood concentration of estrogens, a female hormone. Circulating hormones in postmenopausal women are associated with a risk of heart disease and osteoporosis. Drinking in moderation appears to lower that risk.

The majority of studies showing beneficial effects of alcohol on health use an objectivist approach with aim to test cause and effect relationships between alcohol and health outcomes. However, this approach

is based on a biomedical view and considers two variables that operate in vacuum (Stephens, 2008; Lyons & Chamberlain, 2006). The biomedical view does not take into account psychosocial factors that influence behaviour and affect our health respectively. For example, evidence suggests that social support plays a direct role in physiological processes (Lyons & Chamberlain, 2006), via the hypothalamic-pituitary-adrenal axis and autonomic nervous system. Social support may alter hormone secretion and neuroendocrine functions, influencing lipid and protein levels, which are important factors in onset and progress of cardiovascular diseases (Rozanski, Blumenthal & Kaplan, 1999). Therefore, it is possible that the beneficial effects of moderate alcohol intake are associated with social aspects involved in drinking and not due to the effects of alcohol per se. This may potentially have serious negative health consequences for older people who consume alcohol in isolation, but with a belief in its beneficial health effects.

Positive effects of alcohol on human health should be considered in the context of alcohol use as it may differ across individuals. Potential overestimation of the effects of alcohol consumption should also be kept in mind due to inherited weaknesses in research findings (Connor et al., 2013). For instance, moderate drinking may refer to diverse amounts of alcohol across studies. Therefore, before considering moderate alcohol use as a recommended strategy for good health, it is important to outline negative effects alcohol use may cause to people.

1.6. Pitfalls of drinking

Alcohol causes harmful effects in the human body and directly contributes to over 60 different diseases and conditions (McEwan et al., 2013; Rhem et al., 2009). Alcohol use is associated with diverse types of cancers, gastro-intestinal conditions, cardiovascular diseases, mental disorders and rheumatoid conditions. Heavy alcohol consumption over a long term may cause liver cirrhosis, which is a common cause of alcohol-attributable death in New Zealand men older than 45 years (Connor et al.,

2013). Taking into account that the liver is the main organ for filtering toxins, drugs and other substances in the body, a liver that is damaged by alcohol also affects the work of other organs. Alcohol also causes damage to red and white blood cells affecting functioning of the immune system. Damaged red blood cells may cause blood clotting, while alcohol damaged white blood cells reduce their production of antibodies to fight infection.

Alcohol has been recently identified as a carcinogenic substance (International Agency for Research on Cancer, 2010). Heavy alcohol consumption, defined as four or more drinks per day, is associated with a significant risk of oral and pharyngeal cancer and esophageal squamous cell carcinoma, laryngeal cancer, colorectal and pancreatic cancer. Light drinking, defined as up to one drink per day, is found to lead to an increased risk of 20 percent to 30 percent of oral and pharyngeal cancer and of esophageal squamous cell carcinoma (Pelucchi, Tramacere, Boffetta, Negri, & La Vecchia, 2011). Alcohol also increases the risk of breast cancer in women. Breast cancer is the leading cause of alcohol-attributable death in New Zealand women and accounts for more than 600 deaths every year (Connor et al., 2013). Alcohol consumption is associated with an increased risk of head and neck cancers. In combination with smoking, the risk of cancer is further increased (Myers & Isralowitz, 2011).

Heavy drinking has negative effects on bone density and causes problems in people suffering from a variety of chronic conditions. Excessive alcohol use causes a decrease in bone density in older people and is associated with falls and injuries causing hip fractures and other limb injuries (Johnston & McGovern, 2004; Felson, Zhang, Hannan, Kannel & Kiel, 1995). Heavy drinkers may have concurrent liver disease and a low intake of calcium. They are also likely to smoke cigarettes and drink coffee, which are associated with osteoporosis. Alcohol used by people with chronic conditions further complicates their health issues. For instance, many older people suffer from insomnia and use alcohol to help them sleep. This is problematic because alcohol interferes with regular sleeping rhythms and causes a drinker to awake fatigued (Myers & Isralowitz, 2011).

Alcohol consumed by people who suffer from diabetes may cause serious adverse effects to a drinker. The main task in managing diabetes is

to regulate levels of glucose in the body. Both high levels or low levels of glucose (hypoglycaemia) in people with diabetes are potentially life threatening. Heavy alcohol use, defined as three or more drinks a day, may increase blood glucose, while hypoglycaemia may occur even with moderate consumption of alcohol (HPA, 2013). Hypoglycaemia may also occur in people who are not diabetic, but who drink large quantities of alcohol per occasion. Diabetes affects over 200,000 New Zealanders (HPA, 2013) and drinking even on a social level may have potentially fatal consequences for some people.

Alcohol use has negative effects on our heart and the nervous system. Heavy drinking is associated with heart disease (Mukamal et al., 2009) and alcoholic cardiomyopathy may occur in people who are frequent alcohol users resulting in inflammation and weakening of the heart muscle (Youngerman et al., 2010). Consumed in larger amounts alcohol may also cause irregular heartbeats and sudden death. Alcohol use affects our nervous system causing changes in neurotransmitters and receptors of neurons. It acts as a depressant to many central nervous system functions, affecting judgment, reasoning, fine and gross motor skills, perception, and memory (Myers & Isralowitz, 2011; Youngerman et al., 2010). Consumed in the long-term, alcohol may cause permanent structural and chemical changes in the brain and lead to serious cognitive deficits such as Wernicke's encephalopathy and Korsakoff (amnesic) syndrome, alcohol dementia (Gupta & Warner, 2008), and haemorrhagic stroke (Diaz, Cumsille, & Bevilacqua, 2003; Bond et al., 2005).

1.7. Alcohol and medications

For people who are using medications alcohol consumption may cause serious health complications. Interactions may cause mild effects or lead to deadly consequences. Alcohol may enhance, inhibit or neutralise the intended effects of medications, while some combinations of medication and alcohol may also be fatal resulting in death. For instance, antibiotics are commonly prescribed to treat infection. Alcohol may decrease the

effectiveness of some antibiotics or cause, for instance, nausea and vomiting when used in combination with others. Alcohol also increases sedation for people who use antidepressants causing dizziness and poor concentration (Youngerman et al., 2010). Beer and wine are especially harmful in that regard, because they contain tyramine, a chemical that interacts with antidepressant medications MAOI (monoamine oxidase inhibitors) causing potentially fatal high blood pressure. Alcohol also increases sedating effects when used in combination with antihistamines, used to treat allergies, sleeping pills, pain relievers, as well as antipsychotics and sedatives. Alcohol in combination with heart medications may reduce their effects and cause fatal consequences for some people.

Interaction of alcohol with medications in the aging population may cause significant problems taking into account that the average person older than 65 takes between two and seven medications a day (Myer & Isralowitz, 2011). Results of a recent survey on alcohol use in New Zealand suggest that older adults who suffer from various chronic conditions, such as cancer, asthma and diabetes, drink more alcohol per occasion and more often (McKenzie, Carter & Filoche, 2014) indicating potential significant health problems for many older New Zealanders.

1.8. Influences on mental health

Alcohol use in older people may negatively affect their mental health. Drinking in this population group is associated with anxiety disorders. Alcohol consumed in small quantities has disinhibitory effects and relieves anxiety. However, alcohol consumed in larger quantities and during longer periods may cause anxiety in older people (Plebani et al., 2013). Anxiety is a common disorder among this population and it is estimated that 10-20 percent of older people suffer from some type of anxiety (Geriatric Mental Health Foundation, 2014). However, anxiety is often undiagnosed and misinterpreted as a symptom of other illnesses in older age. Alcohol use is identified as one of the risk factors that contribute to anxiety disorders (Plebani et al., 2013).

Depression is a disorder that tends to co-occur with alcohol misuse. It is characterised by many states from feeling low to not being able to deal with everyday life. It may affect any individual and it is independent of culture, gender or age (Geriatric Mental Health Foundation, 2014). Depression is more common in older people compared to younger generations (Myers & Isralowitz, 2011). Older people are particularly vulnerable to depression due to factors such as adjusting to change and loss, loneliness and isolation, financial reasons, illness, disability and pain. Older people who feel mild depression may use alcohol as a coping tool, which makes depression even worse and results in an increased risk of developing serious mental health problems. Taking into account that some older people may suffer from dementia, alcohol use can make their memory problems and trouble concentrating worse.

CHAPTER 2

2.1. Factors influencing drinking in older people

There are a number of factors that may influence drinking in older people. Socio-demographic characteristics, such as age and gender, and socioeconomic status directly affect alcohol use. In addition, older people have different stressors and risk factors that influence their drinking practices compared to other population groups. For instance, major life events, such as retirement, affect an individual's drinking. Retirement may contribute to an increase as well as a decrease in alcohol use. Loss of financial security, isolation and lower health status are also events associated with older age that may affect drinking in this population group.

Age plays an important role in alcohol use. Evidence suggests that alcohol use decreases with age and it is significantly lower for individuals over 80 compared to older people in their 70s and 60s, who in turn drink less than people in their 50s (Plebani et al., 2013; Moss et al., 2010). This pattern may be explained with a generally higher prevalence of illness and less social contact as people age, as well as changes in their life circumstances. For instance, people in their 50s are likely to hold employment and can afford alcohol, engage in drinking after work and have more social networks compared to people who are retired. Individuals in their 50s are also likely to experience better health and less illness than older generations.

Alcohol use is also seen as a gendered practice. Evidence suggests that internationally women drink less than men (Emslie et al., 2014, Wilson et al., 2013; Babor et al., 2010) and men misuse alcohol more than women (Rhem et al., 2009; Plebani et al., 2013). However, many European countries report that gender differences in drinking are not so great (Simpura & Carlson, 2001) and some evidence suggests that these differences are reducing significantly for cohorts of baby-boomers (Keys, Grant & Hasin, 2008). Taking into account that, on average, women live

longer than men, potential inappropriate alcohol use may create serious health problems for women as they age.

International research suggests that race, educational level and marital status strongly influence alcohol use among older people. In regards to race, Caucasians are found to drink more than other racial groups (Plebani et al., 2013; McEwan et al., 2013). Older people with higher education and higher income are likely to drink more than those with less education, indicating that affordability of alcohol plays an important role in this behaviour. Some evidence suggests that being divorced or single is associated with higher prevalence of problem drinking in this population group (Merrick et al., 2008), while in some studies, living with a spouse or being married has been associated with at-risk drinking (Moore et al., 2006).

Similar patterns of drinking are identified in New Zealand. According to the SoFIE Survey on older people aged 60 years and over (at the baseline), a higher proportion of New Zealand males drink compared to females, widowed males and females are drinking less than those who are married, while divorced or separated males and married females had high prevalence rates of drinking (McKenzie et al., 2014). This pattern of drinking in married older women may be explained with findings of a recent study by Ward et al. (2011) indicating that as women age their responsibility to children and family decreases and they have more time to enjoy themselves. Women's narratives in this study identified wine as a treat to themselves. The SoFIE Survey also identified that individuals with a better self-reported health status drink more than individuals with a lower self-reported health status. Older people on higher incomes reported higher alcohol use and those with higher education are linked to higher alcohol use compared to individuals with lower educational status. Taking into account that educational status is usually associated with higher income, then affordability of alcohol may explain this trend.

Life history plays an important part in alcohol use in later life. Early onset drinkers are estimated to constitute two thirds of the total population of older people who consume alcohol (Babor et al., 2010; Korhonen, 2004). Early onset drinkers usually develop certain drinking practices in their 20s and 30s. Studies found a strong relationship between the quantity of alcohol

consumed per week during the older person's life course and the late life alcohol related problems (i.e. van Gils, Rompaey & Dierckx, 2013). Habitual behaviour associated with drinking may explain this relationship. For instance, individuals may have a habit of having a drink under certain circumstances, such as after work to unwind. Over time, people may feel psychologically habituated to have that drink (Korhonen, 2004). This may further lead to a problem for individuals who are habituated to getting drunk every time they feel stressed. The habituated drinking behaviour may be an issue for baby-boomers in New Zealand whose drinking pattern is influenced by the 'six o'clock swill', which is associated with drinking many drinks (after work) within a short period of time. This pattern of heavy drinking per occasion is still evident in our drinking culture (ALAC, 2006).

Retirement is an important factor that influences alcohol use in later life. It is a period of transition and change that for some people may increase as well as decrease alcohol use. Kuebis and Sacco (2012) in their review on the influence of retirement on alcohol consumption found that contextual factors associated with retirement and individual characteristics affect alcohol use in older people. Individuals who were focused on career and their vocations may feel isolated due to a loss of social networks and work-related relationships. They may also experience loss of purpose once they reach their retirement. Some older people may experience loss of identity during this life stage (Wilson et al., 2013), while others may feel boredom. All of these factors, related to an individual's context and not limited to physiological and psychological characteristics, influence drinking patterns and alcohol related behaviours in older people.

2.2. Alcohol: Cultural and social influences

An account of the positive and negative effects of alcohol use, incorporated with the individual sociodemographic factors described above would remain an incomplete explanation of alcohol use. To consider alcohol use as a choice based on individual preference would be not only superficial but also inaccurate, unless we take into account cultural, social and

environmental factors that are embedded in alcohol and its related behaviours. In order to understand why people use alcohol and why drinking may lead to potentially problematic behaviour, we need to look beyond the pharmacological influence of alcohol on the human body and investigate cultural influences and patterns that are associated with drinking (Mandelbaum, 1965; Heath, 1987; Cagney, 2006).

The relationship between culture, alcohol and social context is complex and multidimensional (Babor et al., 2010). There are many definitions of culture, but in essence, culture refers to ways of life, a system of shared symbols, norms and beliefs, values and customs. The use of alcohol reflects cultural views, values and attitudes, but also imposes certain rules and expectations upon a drinker. Influence of cultural factors on alcohol use is evident in a wide range of behaviours that are associated with drinking across cultures. For instance, in some cultures drinking is associated with violence, while in others drunken people are placid and relaxed. Early cross-cultural research found that in Japanese men alcohol induced pleasant feelings and relaxation, while in Papago Indians drinking resulted in aggressive hostility (Mandelbaum, 1965). These cultural differences are found in many contemporary cultures (Cagney, 2006; Babor, 2010; Myer & Isralowitz, 2011). Culture is fluid and changes with time (Social Issues Research Centre/SIRC, 1998) and views on alcohol change accordingly.

The role of cultural and social factors on what is considered to be appropriate and inappropriate drinking in societies, and the way these factors regulate expectancies related to drinking behaviour was documented by Mandelbaum (1965) in his early work on alcohol and culture. '*When a man lifts a cup, it is not only the kind of drink that is in it, the amount he is likely to take, and the circumstances under which he will do the drinking that are specified in advance for him, but also whether the contents of the cup will cheer or stupefy, whether they will induce affection or aggression, guilt or unalloyed pleasure' (p.4).* Mandelbaum identified alcohol as a cultural artefact, suggesting that meanings of alcohol use are culturally determined, as in any other major artefact. In a similar manner, McAndrew and Edgerton (1969) emphasised that drinking behaviour, termed drunken

comportment, is learned and culturally determined. Their systematic analysis of cross-cultural empirical evidence identified that there are societies in which drunkenness does not result in any 'disinhibited' behaviour, societies in which behaviour associated with drunkenness has undergone radical changes over time and that they are societies in which drunken behaviour varies according to the circumstances in which alcohol is consumed. McAndrew and Edgerton argued that people learn through social interaction what drunkenness is and behave upon that understanding.

Literature differentiates between dry and wet cultures. New Zealand, Australia and the USA belong to dry cultures, where less alcohol is consumed per capita, mainly beer and spirits are consumed and in less socially controlled environments (Cagney, 2006). This pattern is contrary to wet cultures, such as Spain, France and Italy, which report on average higher alcohol consumption per capita and where wine is the main alcoholic beverage consumed during meal times and social gatherings. Alcohol in wet cultures is seen as a part of everyday life, while in dry societies it is considered as a special commodity (Room, 2001). Contrary to levels of average consumption, dry drinking cultures are preoccupied with drinking problems and report more binge drinking, compared to wet cultures, which is associated with crime, accidents, violence and diseases (Cagney, 2006).

As SIRC (1998) suggests, alcohol use in a society is a rule-governed activity and, generally, there is no random drinking. Norms and culturally held views on drinking indicate when, where and how we are going to drink (Heath, 1987). Alcohol is used for different purposes and in accordance with moral, religious and legal norms, and social prescriptions and proscriptions of relevant culture. In some cultures, such as Islamic, alcohol is forbidden from use, while other cultures have less strict norms around drinking. While norms related to alcohol use vary across cultures, solitary drinking is considered a near-universal phenomenon (SIRC, 1998; Babor et al., 2010).

In many cultures people drink for social reasons, such as establishing and maintaining social relationships. This is evident in New Zealand where 'mateship' is implied by drinking (Cagney, 2006). Drinking alone, however, is generally seen as antisocial and problematic. Solitary drinking is widely accepted as a social activity, while there are no cultures in which drinking

alone is encouraged (SIRC, 1998). Evidence indicates that internationally older people mainly drink for social reasons (Wilson et al., 2013; Babor, 2010). Being exposed to opportunities to socialise, such as parties and family celebrations, may potentially increase the frequency of their alcohol use. Friends and family members' attitudes towards drinking may affect the way they drink. The influence of the social environment on alcohol use among older people is documented by Alexander and Duff (1988) who found that older Americans whose friends approve and engage in heavy alcohol use are likely to follow a similar pattern.

Taking into account its social utility, alcohol in many cultures is associated with certain ritual practices, such as buying rounds of drinks and toasting. Sharing and reciprocity, which are foundations of social relations (Myers & Isralowitz, 2011), also apply to alcohol use. Sociability, sharing and reciprocity are reflected in informal regulation, a form of social control, of drinking practices imposed by cultural norms. However, SIRC (1998) suggests that even in the 'compulsory' drinking related to the round buying, drunkenness is not a necessary result. For instance, in the Hmong villages of Laos there are drinking events where the host suggests to a guest to 'match' glass for glass. Hence, the host sets the drinking rate and the guests that attempt to drink over that limit are teased and laughed at (SIRC, 1998). This is contrary to the contemporary New Zealand drinking culture in which drunkenness is the expected outcome of drinking, intoxication is socially accepted and there is minimal social shame associated with publicly displayed behaviours associated with intoxication (McEwan et al., 2013).

Ethnographic literature indicates that many cultures find alcohol use more appropriate for men than women (Babor et al., 2010; Myer & Izralowitz, 2011; Youngerman et al., 2010) and some cultures impose at least some restrictions on women drinking (Heath, 1987). However, these norms are changing. For instance, the women's movement in the 1960s brought changes in drinking practices of women in New Zealand. These were times when the role of women in society changed from stay at home mother to entering a work force and becoming financially independent. In combination with restaurant licensing and availability of alcohol on these premises during this period, women started to drink in public places and

lifted the stigma associated with women drinking in public. This trend continued over time, reducing the gap in gender differences in drinking.

Perception of gender roles in culture has an important effect on drinking practices. For example, recent research on alcohol use among young women in New Zealand found that this behaviour is presented as normal and acceptable in their talk on alcohol and that what used to be a typical 'feminine behaviour' is challenged by gender equality (Lyons & Willot, 2008). Similar findings are recorded in many European countries (see Simpura & Carlson, 2001). However, it appears that drinking among older women may still be subject to stigma. For instance, Emslie et al. (2011) recently found that midlife and older women in Scotland may feel pressured to present their drinking as appropriate and moderate compared to men of the same age. Drinking is a part of culture, and culture is embedded in drinking. It is therefore expected that perception of gender roles and masculinity and femininity in certain cultures are also embedded in drinking practices respectively.

McEwan and colleagues (2013) in their recent book outlined the influence of social and cultural contexts on drinking practices in New Zealand. Authors emphasise that current drinking culture differentiates from the past in not only who is drinking (i.e. men and women) but also what is considered to be acceptable behaviour while drunk, why individuals drink to get intoxicated and how they drink. For instance, expectation of intoxicated behaviour of a typical male drinker in mid 1900s in New Zealand related to drinking lots but not to get drunk, and alcohol was not associated with violent behaviour. However, contemporary drinking culture accepts and celebrates displays of drunken behaviour within a group. ALAC (2006) indicates that the current drinking culture accepts high per-occasion consumption, known as a binge drinking, as normal. The importance of drinking context and cultural norms on drinking practices was documented in a recent study by Grønkjaer, Curtis, De Crespigny and Delmare (2011). Authors found that Danish participants considered as non-normal not to drink and that drinking socially, even above the recommended guidelines on safe drinking, is considered normal if it involves a particular social context, such as 'cosy' gatherings.

2.3. The meaning of drinking

As Heath (1987) indicates, alcoholic beverages are not merely beverages. They are loaded with symbolic meanings, used for different occasions, to facilitate social interactions, as well as for a variety of other reasons depending on individuals involved and their context. SIRC (1998) indicates that drink determines an individual's social world and it is a '*symbolic vehicle for identifying, describing, constructing and manipulating cultural systems, values, interpersonal relationships, behavioural norms and expectations'* (p. 25).

The type of alcoholic beverage in society is generally associated with certain occasions. In some cultures wine is considered as a beverage to be consumed during meal times, champagne for celebration, and beer for relaxation and socialisation. Celebrations, in general, present opportunity for alcohol use. However, as Cagney (2006) suggests, in societies with an ambivalent relationship with alcohol, such as in New Zealand, celebrations are often invoked as an excuse for drinking. This is contrary to societies in which alcohol is seen as part of daily life and celebration and people need no justification every time they drink (SIRC, 1998). This pattern of drinking recorded in New Zealand is associated with alcohol related problems, as indicated in dry cultures drinking patterns. Alcohol is also associated with certain rituals. Cross-cultural research indicates that alcohol is used in many societies to mark certain life cycles, such as birth, death, coming of age and marriage. Some everyday rituals are also noted, such as the daily and weekly transitions from work to leisure (Heath, 1987). In regards to daily rituals, societies in which alcohol is used to define transition from work to leisure are found to have higher levels of alcohol related problems (Cagney, 2006).

Certain types of alcoholic beverages also present a statement of affiliation or identification of belongingness to a specific group. For instance, Guinness is associated with Irish national identity, while whiskey applies the same for Scots. In New Zealand, beer has been historically identified as the most popular alcoholic beverage. It is a part of our national

culture and beer has been particularly associated with men and masculinity. Beer is identified with 'mateship', rugby and racing (McEwan et al., 2013). In recent years, wine gained in popularity among drinkers in New Zealand. Wine is particularly popular among women and it is identified that three quarters of female drinkers over 40 years of age consume wine in this country (McEwan et al., 2013). Globalisation also introduced foreign beverages to local markets. These beverages bring with them 'alien drinking patterns' (SIRC, 1998). Drinkers employ relevant drinking patterns and cause changes in local drinking customs respectively. This type of acculturation brings new trends and expectations related to drinking behaviours. Incorporated with strong marketing messages, they may cause potential problems related to alcohol use.

One of the roles of alcoholic beverages is to act as a social differentiator in regards to gender associated classification, as well as to mark special occasions. In many cultures there are 'feminine drinks', such as RTDs, and 'masculine drinks', such as beer and whiskey. These 'feminine drinks' are mainly implied as being mild and even considered as 'non-alcoholic'. This may have serious negative consequences for individuals, as suggested by MacDonald (1994) who recalls a man involved in a car accident emphasising that he was not drinking as he only had Bacardi and Coke.

2.4. Alcohol and baby-boomers

The influence of sociocultural factors on alcohol use in New Zealand is evident through the change in drinking and drinking practices that generations of baby-boomers initiated. Baby-boomers are considered to be generations raised after World War Two, between 1946 and 1964, and these generations brought a social change in New Zealand in many respects. Cohorts of baby-boomers were influenced by trends imposed by baby-boomers within developed countries and they challenged societal norms and values imposed by their previous generations. Baby-boomers experimented with alternative lifestyles, new types of music, as well as drugs and alcohol

(McEwan et al., 2013). They grew up in the post-war era with sufficient job opportunities and higher levels of income, providing more leisure time for their social activities that included drinking. These cohorts are seen as directly influencing economical, technological and educational changes that are reflected in current drinking culture (McEwan et al., 2013).

Baby-boomers strongly influenced gender drinking patterns in this country. Throughout history, drinking has been seen as a men's practice (Babor et al., 2010; Myer & Isralowitz, 2011). However, the women's movement in the 1960s brought more independence to women in many areas of their life including alcohol use. This period is associated with women lifting the stigma of drinking in public places. This is further reflected in drinking places being adjusted to female drinkers, as many bars in New Zealand changed their layouts and created a 'female friendly environment' in that regard (McEwan et al., 2013). Alcohol marketing discovered new populations of female consumers and drinking became a part of women's lives. Social and historical factors that previously encouraged men to drink excessively became a major influence for women's drinking today (McEwan et al., 2013).

2.5. Alcohol: a biopsychosocial phenomenon

Alcohol is clearly a biopsychosocial phenomenon (Heath, 1987) and drinking behaviours are learned processes influenced by cultural and historical traditions, expectations associated with drinking and being drunk, and the social context of drinking (Cagney, 2006; Heath, 1987). Meanings of alcohol change during life stages for individuals and in accordance with societal norms and what is considered as appropriate drinking (Fillmore et al., 1991; Moos et al., 2010; Babor et al., 2010). For instance, youth drinking can be seen as rebellion, a statement of independence or a part of identity preferences (McCreanor, Greenaway, Moewaka Barnes, Borell & Gregory, 2005). However, drinking in the older population is generally seen as a social act (Wilson et al., 2013; Ward et al., 2011), and older people are not expected to engage in partying and intoxication like young adults do.

It is important to outline that the older population and its different cohorts are culturally and socially diverse. There are many different types of people in this population group and different ways of consuming alcohol. Taking into account that older people live longer in many industrialised countries, cultural views about drinking in older adults may also change with time. Understanding alcohol use among older people in their context, therefore, is much needed. Investigation of contextual meanings of alcohol use from the perspective of individuals who engage in this practice would provide more insight into why these people drink and what alcohol means to them in their context. It is also evident that these meanings may be multiple, due to the different contexts involved.

2.6. Aims of the study

The majority of evidence on alcohol consumption in older people is derived from epidemiological surveys on aging or alcohol (e.g. Moss et al., 2010; Filmore et al., 1991). These studies used a causative approach in showing association of alcohol with adverse health outcomes. Epidemiological studies conceptualised alcohol either as a lifestyle choice or as a living habit (Tolvanen, 1998), indicating its stability over time and across situations. This approach is limited as it largely ignores meanings that alcohol use may have for older people in different contexts. Some studies took into regard personal experiences, situations and expectancies, and identified older people's motives and reasons for drinking using quantitative measures (e.g. Immonen et al., 2011, Kahn et al., 2006; Backett, Davison & Mullen, 1994). Findings of these studies suggest that older people may emphasise social and moral reasons for alcohol use over health reasons. While these studies provide more insight into the personal views of older adults and identified their own reasons for alcohol use, Wilson et al. (2013) indicate that individual reasoning may not be consistent with socially negotiated points of view.

Taking into account current statistics on the growth of our aging population and that alcohol use has increased among older people

worldwide, as well as in New Zealand, it is important to understand alcohol use among this population group. In order to understand why and how older people drink, we need to investigate contextual meanings of alcohol use and why older people drink the way that they do. More research is needed to provide insight into this complex relationship and guide potential health promotions that would acknowledge these influences. This research is conducted in regards to an identified gap in literature and with the aim to contribute to a contemporary understanding of alcohol use among older people in New Zealand, but also to provide suggestions for potential health promotion strategies towards healthier drinking practices among the older population in general. The purpose of this project is to use qualitative methods to investigate social context in which older men and women drink alcohol, how they position themselves in that regard and how older adults negotiate drinking in their context.

The full aims of this project are:

- To understand the meanings of alcohol use for older people who use alcohol and

- To understand older people's reasons for drinking and identify the discourses they draw on to construct their alcohol use.

CHAPTER 3

3.1. Methodology and method

In order to meet the aims of this study and understand drinking among older people in New Zealand, a methodology that would allow for the investigation of alcohol use from the perspective of the participants themselves was required. Taking into account that this study aims for an understanding of the meanings of alcohol use and discourses that older people draw on, a qualitative method was considered more appropriate than a quantitative approach, which is generally concerned with identifying a cause and effect relationship between events. Qualitative methods, on the contrary, are concerned with meanings and enable a researcher to achieve contextual understanding of the phenomenon in question (Lyons & Coyle, 2007). As outlined in the previous chapter on cultural and social influences on drinking in societies, context is not considered as a 'background', context is the constituted part of the alcohol use that this study investigated.

Discourse analysis was a chosen approach for this project. Discourse analysis is based on social constructionist epistemology, which suggests that meanings and meaningful reality are constructed in interaction between people and their worlds (Crotty, 1998). Social constructionism takes a critical stance towards conventional knowledge, challenging the view that what we know is based on objective truth. Instead, it proposes that the ways of understanding the world are built through social processes and they are historically and culturally determined (Burr, 2003). Research that is based on a social constructionist framework examines the ways in which people construct their social reality that are available within a particular cultural and historical context, the conditions within which these ways of constructing are used, and the implications they have for people's experiences and practices (Willig, 2008). Social constructionism is concerned with practices of people within their social context and not those of an independent individual (Stephens, 2008). These epistemological

assumptions are in accordance with the aims of the study and they allow for the investigation of the social location of drinking practices.

Social constructionism suggests that we gain our knowledge about people, objects in the world and ideas during social interactions. Attitudes toward an object are considered to be based on particular discursive practices, such as accounts, and indicate particular social functions. Therefore, meanings associated with alcohol are considered to be a product of social practices in which language plays a central role. As Bakhtin (1981, as cited in Gergen, 1994) points out, words are inherently 'interindividual'. According to social constructionism, language is not a reflection of our reality, it constructs our reality. Taking into account that discourse analysis is concerned with language and its role in the construction of social and psychological life (Willig, 2008), then methodology that investigates talk and its implication for the practice was the choice for the investigation of alcohol use among older people in this study. A careful examination of the ways in which older people talk about their drinking will be a useful way to learn more about *what* it means to them.

To construct meaningful objects, such as alcohol use, people may draw on socially available clusters of themes, ideas and images. These concepts are identified by Potter and Wetherell (1995) as interpretative repertoires and they are also referred to as *discourses.* For instance, one readily identified discourse is a medical repertoire that people draw upon to suggest that alcohol use is a health risk (Tolvanen, 1998). Words and images that are part of this repertoire may include disease and weakness. Potter and Wetherell (1995) indicate that people may draw on different interpretative repertoires to construct an object according to the social function it may serve for the speaker at the particular time. For instance, older people may draw on a medical repertoire of alcohol use in conversation with their doctor or on a social repertoire in talk to their friends, as their accounts serve different social functions in these contexts.

In contrast to discursive psychology, which is interested in interpersonal communication, discourse analysis investigates the relationship between subjectivity (how people think or feel) and its implications for practice (what they do). This type of data analysis views

discourses as facilitating and limiting, enabling and constraining what can be said, by whom, where and when (Parker, 2005). These discourses offer *subject positions*, which, when taken up, indicate a subject's related rights and obligations and a position a person takes within this set of rights (Davies & Hárre, 1990). For instance, older people in their discourse may position themselves as moral persons engaging in alcohol use for social reasons and emphasise their self control over alcohol, which may justify their decision to ignore alcohol related health messages. Wetherell (1998) indicates that when discourses provide inconsistent subject positions, or these positions are exercised by another speaker (e.g. an interviewer), they are usually negotiated by speakers and may reflect only temporary disruption to the presentation of the subject. These moments reflect the constructed and negotiated nature of subjectivity (Stephens, Carryer & Budge, 2004), and will be investigated in this study.

The research questions of this study were directly shaped by the methodology itself. As Willig (2008) indicates, the methodology, through its epistemological assumptions, dictates what we can and cannot ask (p., 21). Taking into account that discourse analysis is informed by social constructionist epistemology, the research questions addressed the social and discursive constructions of alcohol use as follows:

- what discourses do older people draw on to construct their alcohol use?
- how are these discourses used to construct older people's drinking?
- how do the discourses and the different constructions position older people and other subjects in relation to alcohol use?
- what discourses do older people draw on when negotiating alcohol use in their social context?

Data analysed in this study were collected as part of the NZLSA. The NZLSA is a nationally representative longitudinal study of the health, wealth, social, and demographic factors that contribute to positive aging in New Zealanders aged 50-84 years old (New Zealand Association of

Gerontology, 2012). The NZLSA study is funded by the Ministry of Science and Innovation for two waves of data collection in 2010, and 2012, and is run as a collaborative study by research teams at Massey University and New Zealand's Family Centre Social Policy Research Unit. Data were collected during private semi-structured interviews conducted by an experienced interviewer. While the interviews were conducted by another person and not by the researcher, transcribed data is considered as appropriate data for this study. As Willig (2008) indicates, if we would like to find out how ordinary people construct meanings in relation to a particular topic, as alcohol use is in this study, then we can work with transcripts of semi-structured interviews alone.

Semi-structured interviews are the most widely used data collection method in qualitative psychology, and they are compatible with several methods of data analysis, including discourse analysis (Willig, 2008). One advantage of this interviewing style is that the interviewer guides the interview in order to follow certain questions and the topic. It also allows the interviewee to redefine the topic of inquiry and generate new insights for the interviewer. For instance, some participants in their talks on binge drinking provided accounts of current drinking in young people and allowed for the interviewer to investigate this matter further, revealing accounts of the participant's drinking at a young age and a recall of the 'six o'clock swill' and its influence on their drinking behaviours.

In order to obtain detailed and comprehensive accounts from the participants, Willig (2008) suggests that the interviewer should ask for illustrations of events or experiences. This was employed in the interviews by *descriptive* questions that were used to prompt the interviewee to provide a general account of what happened in a certain context, as well as *contrast* questions that allowed for a comparison between events (Spradley, 1979, as cited in Willig, 2008). Some *structural* questions were also asked allowing the interviewee to identify categories and frameworks of meanings that they used to explain their drinking. For instance, the participants were asked how they came to answer the question on how much they usually drank. The interview schedule (see Appendix A) included questions about reasons for drinking, types of alcoholic beverages used and locations where participants

usually drink, what they consider to be moderate and excessive drinking, awareness of New Zealand guidelines for safe drinking, as well as reasons for change in their drinking over time.

3.2. Procedures

3.2.1. Participants

A sample of 18 individuals (seven male and 11 female, aged from 53 to 74 years) was recruited from NZLSA. All participants were living independently in the community and they were comfortable communicating in English. Potter and Wetherell (1995) indicate that even less than 10 participants will ensure richness of data, as the focus is on discourse pattern and not on the individual. However, in regards to the research topic, data gathered from this sample size is considered to be more informative in identifying dominant discourses in the selected age group. This study aimed for understanding of alcohol use among older individuals aged over 50 years. Participants aged 50 and above were included in order to consider views leading up to and following the transition of retirement.

Participants were selected on the basis of their reported drinking status (light to heavy drinker), as identified with the Alcohol Use Disorder Identification Test-C (Audit-C) in the 2010 NZLSA survey, and location in the Manawatu (n=8) or Horowhenua (n=10) regions in New Zealand. The Audit-C is an internationally recognised screening test for identifying excessive alcohol consumption in individuals (Bradley et al., 2007). The AUDIT-C comprises of three questions and it is scored on a scale of zero to 12. Scores of zero reflect no alcohol use in the past year, while four points or more for men and three points or more for women is considered positive for alcohol misuse (Bradley et al., 2007). Higher scores on AUDIT-C, in general, suggest that drinking is affecting an individual's health and safety. All participants completed the Audit-C measure for the second time at the start of the interview. Final Audit-C scores for the present study ranged from one to eight. Eight participants (five women and three men) were responsible drinkers and 10 participants (six women and four men) were

categorised by their AUDIT C scores as potentially hazardous drinkers. NZLSA 2010 data indicated that four participants had diabetes and another two had heart conditions; other health conditions (e.g., cancer, anaemia, high blood pressure) were present for some participants in the sample.

3.2.2. Ethics

Ethical approval for this project was gained from the Massey University Human Ethics Committee. All participants were initially presented with an Information Sheet (see Appendix B) detailing their involvement in this project including the participants' rights to withdraw from the project. The Information Sheet included the contact details of the interviewer and alcohol related services they may contact in the case of any discomfort caused by the interviews. The participants signed the consent forms (see Appendix C) prior to interviewing. The interviews were audio recorded and transcribed by the interviewer. Pseudonyms have been used in the transcribed text and any identifying details have been changed. All interview transcripts and sound recordings are securely stored for five years. The present researcher signed the Confidentiality Agreement for Co-Researchers (see Appendix D) declaring her duty to keep all information related to this project confidential.

3.2.3. Data analysis

Recorded interviews were transcribed by the interviewer and transcribed text was subjected to discourse analysis by the present researcher. The researcher read each transcript several times to gain a familiarity with the content, and the analysis of discourse followed six stages recommended by Willig (2008).

Stage one of the analysis involved identification of different ways in which alcohol use was constructed in older people's talk. The researcher focused on identification of explicit as well as implicit ways in which the discursive object is presented, and not only on the keywords. Alcohol use was identified via direct lexical references, as well as shared meanings presented in the text. Identified passages related to alcohol use were coded according to identified recurring 'themes' using qualitative data analysis

software ATLAS.ti. ATLAS.ti is computer software that allows a user to identify, code and comment on findings in primary data documents. This software supports the definition of relations between categories which are not hierarchical and assist a researcher in creating links between individual quotations and codes (Alexa & Zuell, 2000). ATLAS.ti also enabled the researcher to use a variety of up to seven types of semantic relations, such as cause of _, part of _, etc., to link two codes or quotations. It is important to note that this software is a tool that *supports* qualitative data analysis, rather than analyse it. The researcher was in charge of the intellectual work related to identifying codes and relationships between them.

After initial identification of all sections of the text that contributed to the construction of the alcohol use, the researcher proceeded with stage two of the analysis and focused on differences between constructions. The aim in this stage was to locate diverse constructions of alcohol use within wider discourses. For instance, older people drew on the 'health issue' discourse when they described negative effects associated with alcohol use, or the 'social life' discourse in explaining their reasons for drinking. Therefore, alcohol may be constructed as a social tool as well as a health issue within the same text.

In stage three the researcher focused on the analysis of the *context of discourse* and what function it served for the interviewee. This refers to *action orientation* of the discourse and what was gained from constructing the discursive object in a particular way. This action orientation of discourse allowed for an understanding of what the identified object constructions were intended to achieve within text and to what extend did they fulfil the functions intended by the speaker, such as to promote one version of events over another (Willig, 2008). This stage was focused on identifying why alcohol use was constructed in this way by the interviewee, what function it served for the speaker at this particular point in the text and how this construction of alcohol related to other constructed versions in surrounding text.

Stage four of the analysis focussed on identification of the *subject positions* offered by various discursive constructions of alcohol use. These subject positions relate to interviewed participants, other people they

referred to in the text as well as constructed objects. Analysis during this phase was focused on identifying the patterns of talk about alcohol use which had implications for how older people negotiated their own drinking and judged the alcohol use of others. These subject positions identified by discourses provide moral and social identities from which people can be judged and judge others. Discourse analysis in that respect allows us access to social expectations that govern the ways of being in and seeing the world.

In stage five of the analysis the researcher focused on identification of the relationship between discourse and practice and considered the possibilities or limitations for action. This was done through the systematic exploration of the ways in which discursive constructions and the subjects' positions taken by the participants within them open up or close down opportunity for action. The question asked in this regard was: What can be said and done from within different discourses? This phase was concerned with identifying what was the intended action of the discursive construction identified in the text.

In stage six of the analysis the researcher investigated the relationship between discourse and subjectivity. This stage was concerned with the outcomes of adopting various subject positions by drawing links between discursive constructions and the interviewee's personal experiences. The aim in this phase of analysis was to reconstitute what it means to be a person located in particular discourses. The question asked was: What the interviewee could have felt, experienced and thought from within various subject positions identified in discourses? For instance, it can be investigated what it means for a male participant to position themselves in a masculine drinking discourse (i.e. drinking as a 'man') and how that affects their subjective everyday experiences. This may result, for instance, in the participant engaging in heavy alcohol use and actually feeling less guilty about his heavy drinking, as that is 'what a real man does'.

An important part of the data analysis was the researcher's awareness of reflexivity. As Willig (2008) indicates, discursive psychology suggests that the researcher 'authors', rather than discovers knowledge. Therefore, a reflexive awareness of the researcher's contribution to the construction of meanings was important during this phase. This was done

through personal reflexivity and the acknowledgment that the researcher's values, personal experiences, interests and world views influenced the research process and choice of research method. In regards to epistemological reflexivity, the researcher reviewed and reformulated research questions during the research process in order to align them with epistemological assumptions of methodology and method used in this study. However, the researcher was also aware of the possibility to fall into a 'methodolatry' (Lyons & Coyle, 2007; Lyons & Chamberlain, 2006) and become preoccupied with a research method over other considerations in the research. A regular consultation with the research supervisor and the researcher's ongoing reflection on the research itself and its underlying assumptions assisted the researcher to be aware of this possibility.

In doing discourse analysis there are some pitfalls that the researcher was aware of and ensured certain steps to avoid them. Parker (2005) indicates that it is relatively easy during discourse analysis to slip into thematic analysis or even content analysis, unless we have good understanding of discourse analysis. Therefore, the researcher gained a thorough understanding of Willig's (2008) six stages in conducting discourse analysis and became familiar with it. The researcher tried to avoid idle curiosity and focused on the research questions and study aims, which ensured that the data analysis was not going in a different direction. Also, data was linked into discourses rather than being sorted into themes. By sorting data into themes we may inaccurately suggest something that is beyond the speakers' intentions.

One of the pitfalls in doing discourse analysis relates to a researcher's tendency to reduce things that are said to what the speaker really means, and possibly even speculate about psychological characteristics that may explain why something is being said. Therefore, the researcher kept in mind that in doing discourse analysis we are trying to understand discourses that the participants draw on in order to construct subjects and objects, and avoided deeper psychological explanation that may underlie these discourses. Finally, this is the only reading of the text and the researcher does not make a claim that it is completely accurate. It is possible that other readers may derive different interpretations and

specifically if they employ a different theoretical framework in guiding these interpretations (Parker, 2005).

CHAPTER 4

RESULTS

Analysis of the transcripts resulted in the identification of dominant discourses that were drawn upon by the participants in their talk about alcohol use. The dominant discourses are outlined in this section including brief quotations as examples related to constructions of discursive objects and subjects, action orientation of these constructions, positions taken by speakers within these discourses and the implications these discourses and constructions have for the participants' practice and subjectivity. Examples have been incorporated into the interpretative accounts and provided along with the interview number and numbered lines to refer to the quotes throughout the text.

4.1. A 'social life' discourse

A 'social life' discourse was commonly drawn on by participants when they described their drinking behaviours. This discourse was used to construct alcohol use as an integral component of social gatherings. Some descriptors and images used by participants who drew on this repertoire to talk about their alcohol use were: 'parties', 'special occasions', 'socialising' and 'social events'. The 'social life' discourse was used to construct alcohol use positively and as something that allows a drinker to obtain greater satisfaction in a social situation. Drinking alcohol was commonly described as a practice participants do as part of the group. As such, it offered the benefits of a social setting and allowed participants to feel included in the social group. Use of this discourse ensured participants' positive positioning as a social person and one who has friends and attends social events, and not a person who does not fit into a social occasion.

4.1.1. It's customary

Participants commonly talked about drinking alcohol during social gatherings and celebratory occasions, such as birthdays and Christmas parties. They described their alcohol use as behaviour consistent with traditional expectations related to drinking alcohol during social events. Participants used the 'social life' discourse to construct alcohol use positively as an expected part of the social gathering. Constructing alcohol use in such a way allowed for normalisation and generalisation of drinking alcohol in that context. For example, in the following excerpts the participants constructed alcohol use as an object that is a customary and expected component of social gatherings.

[Carl] It (alcohol use) *is just one of those traditional things you do on a social occasion isn't it.* (Int. 8)

[Bonnie] Because it was sort of a celebration you think 'crack open a wine'. (Int. 5)

[Paul] It's what you do if you going to the rugby: have a beer. (Int. 11)

[Doreen] So you've got special food and special desserts and so yeah it's an occasion to have a glass of wine and whatever. (Int. 12)

Participants in these quotes positioned themselves favourably and claimed an identity of a good drinker and one who is consistent with traditional expectations. They emphasised appropriateness of drinking alcohol during social gatherings and normalised their alcohol use. As suggested by Paul, drinking beer when going to the rugby is 'what you do'.

The importance of drinking alcohol during social events and its role in signifying the occasion was frequently talked about. For example, Carl and James, in the following excerpts noted how it would be a 'lesser occasion' if there had been no alcohol during the social gathering, which works to construct their alcohol use positively.

[Carl] Yes, I think it would have been a lesser occasion
if there had have been no alcohol there, put it that way. (Int. 8)

[James] I think yes for them, for the children and even for my wife
it would have detracted from the occasion if she hadn't been able
to put a bottle of wine on the table and say,
'This wine here or there is some spirits there for, or there is
some beer in the fridge'. (Int. 15)

Normative expectations related to drinking alcohol during social gatherings were frequently spoken about. Participants drew on behaviours and ideas of feelings to be a norm associated with drinking in that regard, and described alcohol use as an integral component of hospitality and reciprocity. By talking about alcohol use in these terms and negotiating drinking around social norms, participants positioned their drinking behaviours as acceptable. For example, Doreen in the following account positioned herself positively, avoiding negative positioning of a bad host. In a similar manner, Rose (line 21) invites evaluation of this drinking behaviour as positive ('it's just the norm isn't it?').

*[Doreen] And it (*alcohol*) is sort of expected. If people come*
to your house... We're very hospitable people. We have
people around here a lot. So if we suddenly said to them
oh you're not getting a drink
they'd think that we'd lost all our money or something. (Int. 12)

[Rose] I suppose it's just the norm isn't it,
that you take a beer or a wine if you're going somewhere. (Int. 9)

Participants used the 'social life' discourse to construct alcohol use as a constituted part of their social lives and an integral component of social gatherings. They normalised alcohol use in that context and justified their drinking as traditional and normative behaviour. Emphasising propriety over

their alcohol use participants positioned themselves as good drinkers and being consistent with traditional behaviour in relation to consuming alcohol during social events.

4.1.2. Social facilitation

Participants frequently talked about social benefits of drinking. They described their alcohol use as a practice they do for social reasons, mainly at their own or other people's homes. Meeting, interacting, talking, as well as telling jokes, are identified as a part of the 'social life' discourse, which was used to construct alcohol use positively as an object that enables these activities. Drinking alcohol offered the benefits of relaxation and sociability for participants. They commonly talked about alcohol providing them with confidence and facilitated the process of social interaction, for example:

*23 [William] It (*alcohol*) may have loosen up things you know.*
24 Because I'm shy.
25 Normally shy until I get to know someone. (Int. 13)

26 [Carl] So I think particularly in that environment where you don't
27 know people and you've got to make a certain amount of small-talk
28 and so forth it (alcohol) *just kind of helps lubricate the conversation*
29 a bit and relaxes people a bit. Yeah. (Int. 8)

30 [David] Oh, a little bit more relaxed (when drinking) I suppose, as
31 you do. You tell more jokes. You pick on other people more so.
32 That sort of thing. (Int. 6)

33 [Hannah] I can be very outgoing but sometimes I can tend to step
34 back and survey the, yeah, until you get that confidence.
35 Interviewer: So did the alcohol give that confidence?
36 [Hannah] It probably did, yeah. I think so. (Int. 18)

Alcohol use in these excerpts was constructed as a social stimulant that enables participants to feel comfortable and provides them with

confidence and desirable social skills. For example, for William it helps him 'loosen things up' (line 23). In a similar manner, Carl and David constructed alcohol use as a social lubricant that helps with conversation that they otherwise would be reluctant to make. By talking about alcohol use in these positive terms, participants constructed their drinking as acceptable. They positioned themselves favourably and described their drinking in terms of unique properties that alcohol use has on the human body and indirectly on social interactions. For example, David in the following excerpt constructs alcohol use as a social facilitator and indicates its beneficial effects on the drinker during a social meeting:

37 [David] I suppose the alcohol just relaxes people and they become
38 more sociable and I've always said to people, in the old days or
39 when I was a drinker as a younger person, you could drink, I don't
40 know, a flagon which was a gallon of beer. If someone offered you a
41 gallon of water, you wouldn't be able to drink it so there's
42 something there that relaxes you and makes you more relaxed to
43 have that social meeting, I suppose. (Int. 6)

Participants commonly described drinking alcohol as a practice that *we* do in relation to being part of a social group. These constructions indicate that identity, or being part of the group, is an important aspect of their social lives. Some participants reported drinking alcohol only in the group setting, as that is what others in the group do. They explained their alcohol use in terms of allowing participants to feel part of the group. The following excerpts indicate how participants constructed alcohol use as behaviour that is consistent with the social group setting.

44 [Doreen] Oh just to be sociable really oh and all our friends love a
45 glass of wine or a beer or something. Mostly wine. All my lady
46 friends-we all drink wine.
47 So it's just a social thing that we do. (Int. 12)
48 [Paul] There would be meeting up with friends -
49 just socialising if you like. (Int. 10)

50 [Lauren] The reasons I drink.
51 It's just to be sociable I would say. (Int. 14)

52 [Sofia] But yes, with those group of friends it's probably
53 because it's part very much of their lives. Like every day.
54 And it's not mine. So, I just join in with that.
55 They drink and I drink too when I'm around them (Int. 4)

These quotes illustrate the importance of alcohol use as a means to socialise with others. For example, Sofia in her account takes a position of someone who does not use alcohol every day, but justifies her drinking with an increased comfort and group identity that alcohol use provides for her in the social group. In a similar manner, Lauren in her transcript positioned herself as someone who does not like alcohol, but consumes it as a part of a group. This suggests that alcohol use may be considered as a social necessity that secures a place in the group. This positive construction of alcohol use allowed participants to construct their drinking in a group setting as positive and acceptable.

Participants commonly used the 'social life' discourse to position themselves as a social person and established undesirability for negative positioning as a non-social person if they chose not to drink in the social setting. For example, Bridget in the following excerpt indicates her sociability, while she closed an opportunity for negative positioning as someone who is a 'spoil sport' if she doesn't accept a drink in the social setting. Bridget indicates that being a part of the social group is important to her and that 'a drop on the bottom' (line 58) will secure her identity as a social person. James in his quote also avoids negative positioning as a 'teetotaller', while taking the position of a social person but someone who is in control of his drinking. James throughout his transcript positioned himself as a responsible and controlled drinker and someone who uses strategies which are incorporated in the social group expectations.

56 [Bridget] I did (drink).
57 Not to appear like a spoil sport. [laughed]
58 Just a drop on the bottom to be sociable (Int. 7)

59 [James] I guess it is fit in with the group if the group norm is to have
60 a small quantity of drink, I'm quite happy not to be that extreme
61 that I say, 'No I can't drink with you. I never drink.'
62 I'm not a teetotaller
63 but I model the behaviour even to relatives I guess. (Int. 15).

While participants constructed alcohol as an important factor in being able to enter a social setting or gain the sense of being accepted as part of a group, they commonly reported not being pressured to drink (more) in the group setting. Participants associated pressure to drink in a group with young people, while drinking alcohol to feel included in a group was related to drinking any quantity of alcohol (as suggested by Bridget, lines 57-58) as long they drank some.

One use of constructing alcohol use as a social facilitator was to differentiate drinking alcohol for social reasons from other reasons of alcohol use. This is illustrated by Vicky in the following excerpt, who described alcohol use in the group setting as a means of 'catching up'. In a similar manner, David and Sofia in their accounts constructed drinking for social reasons as positive and acceptable, while they referred to drinking alone or for reasons of coping in negative terms.

64 [*Vicky*] *Just sitting around and really and enjoying drinking*
65 something a little bit different, and enjoying one another's company.
66 Although, it was focused around drinking, but it was different sort
67 of drinking, it was as much catch up for everyone as well. (Int. 1)

68 [David] I mean I don't drink when I'm depressed or
69 anything like that, you know, will help the day go by
70 or anything. No. It's usually a social occasion. (Int. 6)

71 [Sofia] With the food and on occasion with the people who are
72 around. It's not something I do by myself for the hell of it. (Int. 4)

Participants in these quotes constructed alcohol use as a social tool, which worked to position them positively, normalise their drinking behaviours and present it as acceptable. This positioning allowed participants to feel good about their alcohol use, indicating its propriety, providing support for their views being socially constructed in response to a particular context.

4.2. A 'drinking to relax' discourse

Participants frequently talked about winding down and marking the end of the day or week to be one of the reasons for their drinking. Alcohol use in that context was associated with leisure and taking things easy. Some images and descriptors used by participants who drew on this discourse were: 'winding down', 'closing of the day' and 'relaxing'. Participants who have drawn on the 'drinking to relax' discourse constructed alcohol use in positive terms, as an object that provides unique positive sensations to a drinker. For example, Sofia in the following excerpt constructed alcohol use as a relaxant that brings her a positive embodied experience when in need of relaxation.

73 [Sofia] But sometimes when I'm really exhausted and really tired,
74 I don't know why, but that little slosh of vodka in the lime and soda
75 sometimes just seems like a really nice idea. And it does give me
76 that little fuzzy, warm, more comfortable feeling. (Int. 4)

Participants commonly talked about alcohol use being a part of their lifestyle and well established rituals. They referred to drinking alcohol as a part of their routine and daily rituals implying its usualness and normality. Alcohol use was associated with positive feelings and behaviours, and as a tool that enables them to relax and take things easy. For example, the

following excerpts illustrate how some participants constructed drinking alcohol as a ritual and means to relax.

77 [Katrien] it is winding down – the closing of the day
78 and then we brush our teeth and go to bed. (Int. 10)

79 [David] For us, it was just a time of get together, sitting
80 together, have a chat about what's happened at each other's
81 work and then you have a relax and the news comes on
82 so you go and watch the news or whoever (Int. 6)

83 [Bonnie] You know the end of the day - in the evening on
84 the weekend I think it's time to relax and I find that glass of
85 wine is part of that ritual of starting to enjoy the evening. (Int. 5)

86 [Paul] I suppose it (alcohol) is a means to relax and it signifies
87 that the weekend is here and you know that's what you do. (Int. 11)

In these excerpts Katrien and David constructed alcohol use as a part of their daily activities and described drinking alcohol as functional behaviour they mainly do at night and after work. The usualness and normalisation of drinking to wind down is evident in Katrien's account (lines 77-78), as she indicates brushing teeth and going to bed being also daily rituals. However, for some participants, like Bonnie and Paul, drinking to wind down is associated with the weekend. This suggests acceptability of drinking alcohol for reasons of relaxation and winding down, and related to the context and circumstances of drinking.

Participants commonly described alcohol use as a means to wind down after work and to relieve pressure associated with daily living. When negotiating drinking in that context, participants justified their drinking with the comfort it provides them in relieving stress and as a deserved reward for efforts. For example, Vicky and Sylvia in the following accounts provide justification for their drinking as hard work and stress associated with it.

88 [Sylvia] I've had a stressful day at work. I was tired. I went
89 home, poured a glass of wine, sat down, drank it in about
90 15 or 20 minutes, and thought, 'Damn it,' and put telly on,
91 and poured another one and finished watching a programme
92 that was on telly. (Int. 16)

93 [Vicky] Or if we've had a hectic week. Being self-employed
94 some weeks are horrendous and come a Friday night we might
95 just decide to have a gin with tea, or before we have tea.
96 Just because we feel we've earned it! (Int. 1)

One use of the 'drinking to relax' discourse was to differentiate alcohol use for reasons of relaxation and leisure from habitual drinking and using alcohol to get drunk. The following excerpts of Sofia and David illustrate how these participants constructed drinking alcohol for reason of relaxation positively, and used the 'drinking to relax' discourse to position habitual drinking and drinking for reasons of getting drunk negatively.

97 [Sofia] If you have a really stressful day then sometimes
98 the relief, the relaxation, the annihilation from alcohol on
99 the very rare occasion would be beneficial.
100 But more than, habitually it's not good. (Int. 4)

101 [Earl] Just relaxing. Relaxing. I don't do it to get drunk-
102 I do it because I enjoy a glass of wine. I could sit here, so
103 I'll come home this evening, after the bowls, I'll have a couple
104 of wines down there, come home, small glasses, sit down here
105 and [inaudible] bottle of wine and tea will nearly be ready,
106 and that's that. So basically it's the atmosphere. (Int. 2)

Participants in these excerpts constructed their alcohol use positively and as something they do for leisure. They emphasised appropriateness of drinking alcohol to relax and positioned them favourably. This worked for

participants to avoid the negative position as a habitual drinker and one who drinks to get drunk.

Participants who have drawn on the 'drinking to relax' discourse constructed alcohol use as a part of their lifestyle and associated it with pleasurable embodied experiences. They rationalised their drinking in terms of deserved rewards for efforts and the pressure of everyday living. Participants claimed the positive position of a good drinker and positioned habitual drinking negatively. By talking about their alcohol use in this way, they constructed drinking to relax as acceptable. This allowed participants to claim control over their drinking in this context.

4.3. A 'functional drinking' discourse

Being in control of alcohol use was commonly talked about. Participants described their drinking behaviours as regulated and well controlled and used this discourse to position themselves as a controlled drinker - one who will not get drunk or display negative behavioural outcomes of drinking. They described their alcohol use to be within (their personally imposed) limits and closed an opportunity for being perceived as someone who is not in control of their drinking. Some descriptors and images used by participants who drew on this discourse were: 'control', 'being in charge of oneself', and 'knowing limits'. The following excerpts illustrate how participants constructed their drinking behaviours and the positive positioning they take within these constructions.

107 [Hannah] I always make sure that it's only about,
108 I keep in control. I'm still in control.
109 If I have three or four I know exactly what's happening
110 and you know, I'm under control. (Int. 18)

111 [David] I know that if I drank two bottles in ten minutes, then
112 I know that I'm only going to drink another one because basically
113 three, on the odd occasion four, is my limit. That's where

114 I know that I go to, so if I drank three in ten minutes say,
115 I know that's where I'm going to stop anyway or I could drink
116 three in two hours and that's where I stop. (Int. 6)

117 [Bonnie] Just because it's enough. One of those little bottles fills
118 two of those little plastic cups that they give you. That's more than
119 enough for me. In fact I sometimes don't drink the whole bottle
120 but yeah - that's plenty.
121 And I feel fine. (Int. 5)

Participants in these quotes reveal that it is important for them to stay in control of their behaviour when drinking. For example, for Hannah (lines 107-108) controlled drinking is 'knowing exactly what is happening', while for Bonnie (line 121) it is about 'feeling fine'. These excerpts indicate individual standards around alcohol use that participants associated with control. For example, there is a difference in the volume of alcohol that Hannah (line 109) and Bonnie (lines 118-119) associated with controlled drinking. However, they both claimed the positive position of a drinker who keeps in control of their drinking behaviour.

Participants used the 'functional drinking' discourse to avoid being positioned negatively as an alcoholic and one who is alcohol dependent. For example, in the following excerpts Rose and Earl claimed the identity of a controlled drinker who is in charge of their drinking, while they constructed someone who is in need of alcohol negatively as an alcoholic.

122 [Rose] I don't need more than one. I don't need any but one's nice.
123 I don't have a problem stopping. (Int. 9)

124 [Earl] As I say it's well controlled. I'm not an alcoholic. (Int. 2)

The identity of a controlled drinker, as taken by Rose and Earl in these excerpts, is developed as regulated and disciplined and differentiated from the lack of control typified by 'alcoholics'. Controlled alcohol use is determined by the choice, as suggested by Rose (lines 122-123), indicating

that she is not in *need* of alcohol, but that having one drink is nice. Constructing alcohol use as a behaviour done through choice implied control over one's own actions and suggested non-dependency. This works to allow participants to feel good about their drinking and present their alcohol use as acceptable.

The 'functional drinking' is a readily available and important discourse that participants used to construct their drinking behaviours. It was used to differentiate a controlled drinker from 'an alcoholic' and revealed stigma associated with alcohol dependency.

4.4. A 'health issue' discourse

Participants did not refer spontaneously to negative effects of alcohol when discussing their alcohol use. When specifically asked by the interviewer about negative effects of alcohol consumption on health, the participants commonly drew on the 'health issue' discourse showing a level of shared understanding that alcohol use is harmful for human health and has many adverse effects. Participants expressed awareness of a variety of diseases associated with alcohol use, and the risks and consequences of drinking. Some descriptors and images used by participants who drew on this discourse were: 'sickness', 'disease', 'addiction' and 'depressant'. In order to avoid negative positioning of an irresponsible drinker who engages in unhealthy or risky behaviour, participants resisted this discourse. The following section outlines how the participants used this discourse and the ways they resisted being negatively positioned in that context.

4.4.1. It's a medicine

Participants described alcohol use as beneficial, when used in moderation, and as a substance that provides the drinker with some health benefits. They commonly talked about scientifically identified beneficial properties of red wine on human health and the prevention of heart diseases. Participants constructed alcohol use positively as a medicine to resist the negative subject position of the 'health issue' discourse; a drinker whose

alcohol use may cause health problems. This allowed the participant to position themselves favourably as one who takes care of his health. The following excerpts illustrate positive constructions of alcohol as a medicine and favourable positioning that speakers take within these constructions.

125 [April] Well apparently red wine is supposed to be good
126 for your heart isn't it? (Int. 3)

127 [Rose] Okay, because I know a guy who has had
128 a triple bi-pass and he can drink red wine.
129 He calls it rehydration therapy. (Int. 9)

130 [Carl] there has been some publicity about drinking a small
131 amount of alcohol is good for your health and
132 there has been some publicity about drinking red wine as being
133 good for your health because it's got come antioxidants and
134 so forth in it. So, when I do drink wine – I mean I don't think
135 those two things make a difference to the total amount that I
136 drink, but when I do drink wine, I make a point of drinking
137 red rather than white for that reason. (Int. 8)

138 [James] Yes, I think in a way it's almost like a preventative. I say,
139 'Well it (alcohol) *is probably doing my health some good.'* (Int. 15)

These excerpts illustrate how participants worked to avoid negative positioning in regards to the acknowledged adverse health effects of alcohol use. They constructed alcohol use in positive terms, such as 'rehydration therapy' and 'antioxidant' (lines 129 and 133), and reasoned their drinking with preventative measures for their good health. Participants justified their drinking with an expert's health information, as indicated by Carl (lines 130-131) and suggested that their alcohol use was an appropriate response to it. Constructing alcohol use in such positive terms allowed participants to position themselves as a healthy drinker.

While participants frequently talked about the benefits of red wine on human health, some participants spoke about using alcohol to help them sleep and manage their health conditions. This finding suggests that reasons for alcohol use vary according to the participants' health status and the context in which alcohol use was discussed. For example, in the following excerpt participants constructed alcohol use in positive terms as an object that provides them with some relief from their health conditions.

140 [Rose]Oh, because I didn't have to drive, go anywhere,
141 drive anywhere, just go to bed.
142 Thought it (alcohol) *might help me sleep.* (Int. 9)

143 [Sofia] It helps manage tiredness rather than discomfort.
144 Mood, rather than. I don't see it as helping a health condition.
145 I see it as helping a mood condition, dealing with it, I'm sick
146 and tired of being. I might sleep a little bit better if I have
147 a decent vodka. Yeah. (Int. 4)

In this instance, Rose constructs alcohol use as a sleeping aid. She indicates that she drank alcohol to help her sleep because she didn't have to drive, which allows her positive positioning. In a similar manner, Sofia constructs alcohol use as a sleeping aid and coping tool used to help manage her health condition. Sofia throughout her transcript positioned her drinking as moderate and controlled.

Participants commonly talked about alcohol use as a health issue associated with the excessive drinking of *other* people. They used the 'health issue' discourse to position the heavy drinker negatively and differentiated it from *their* moderate drinking. For example, Vicky and Earl in the following excerpts constructed alcohol use to be a problem of heavy drinkers, while they positioned themselves positively and as someone for whom alcohol is not an issue.

148 [Vicky] Well only, I always assume that big drinkers, who
149 drink to excess, always have the issues with their liver.
150 And the menopause thing but who knows? But apart from that,
151 I suppose if you are a big drinker, you've just got the ongoing
152 things of tending towards alcoholism which has a whole lot
153 of effects on your life. Not getting out of bed and go to work.
154 Not being able to work through a full day without having a drink.
155 For me that's not an issue. (Int. 1)

156 [Earl]Yeah because basically it makes you tired and your
157 blood count goes, I don't know, and you tend to relax more and
158 just sit down rather than be …. Mentally it (alcohol) *doesn't*
159 affect me, it doesn't make me depressed or anything like that.
160 Some people it does. My wife cannot handle too much drink.
161 Very, very rarely she will have excessive drink but being
162 more or less in control, I look after my health fairly well. (Int. 2)

In these excerpts both Vicky and Earl construct alcohol use as a health issue of people who drink to excess and one with which they did not identify. They claimed control over their drinking and a position of someone who takes care of their health. This shift of alcohol use as a health issue of other people allowed them to adopt the favourable position of a healthy drinker and someone who is in control of their drinking and their health.

Participants also talked about not drinking alcohol as potentially harmful for the health. This is illustrated by James, who positioned 'the teetotallers' negatively and justified his own drinking with compliance with an experts' health advice. Emphasising the health benefits of drinking in moderation and constructing not drinking alcohol as potentially hazardous worked to secure James' positioning of a healthy drinker.

163 [James] So being a the teetotaller can be hazardous to your
164 health too!
165 I'm in the middle of the road with what the experts seem to say
166 that is a healthy level of consumption,

167 if there is such a thing, keep it down to a drink a day and
168 try not to do it every day, seem to be the feeling.
169 A small amount of alcohol does have some benefits (Int. 15)

Some participants, including James (lines 165-166), used the 'health issue' discourse to position moderate alcohol use as acceptable. They emphasised benefits of drinking in moderation on their health and referred to it as a 'good way of drinking'. The following excerpts illustrate how participants constructed drinking in moderation.

170 [Bonnie] (Moderate drinking is) *Not over drinking. Drinking*
171 within what your limits are. Drinking for pleasure rather than
172 to get drunk or high or whatever. (Int. 5)

173[David] Moderation I think, is in the social gathering where
174 you have a few drinks of whatever and
175 to enjoy a meal or to celebrate something (Int. 6)

176 [Carl] I think a moderate drinker is someone who can have
177 a drink any time that they feel the desire, whether it's on their
178 own after a hard day's work, or on a social occasion or whatever.
179 And drink after work whatever they want
180 but they're not dependent on it. (Int. 8)

181[Sofia] Drinking in moderation is drinking socially, not on your
182 own for the sake of drinking. And probably no more than once or
183 so a week unless there is a very special occasion to cause it
184 to come up. And two to three glasses of wine. (Int. 4)

Participants in these excerpts constructed moderate alcohol use as an acceptable way of drinking and commonly described drinking with others and not to excess, rather than drinking alone, as indicated by Sofia (line 181). Drinking alcohol for pleasure rather than for need and in the social context rather than alone differentiated acceptable from non-acceptable

alcohol use. Constructing moderate drinking in such a way ensured normalisation of the participants' alcohol use. The positions that the participants took allowed them to feel good and in control of their alcohol use and their health, implying healthy drinking practices that are beneficial for them. They talked about their drinking in terms of health and normal behaviour. For participants, drinking in that context was constructed as positive and acceptable, as long as it's perceived as controlled and moderate.

4.4.2. Older and wiser

Participants referred to a change in their alcohol use as they aged in comparison to drinking in their youth. They described their current alcohol use as sensible and commonly reported a decrease in their drinking over time. Participants reasoned their current levels of drinking around health concerns and positioned themselves as older and wiser when it comes to their health and alcohol**.** By talking about their current drinking behaviours in a positive way, they resisted the 'health issue' discourse. The following excerpts indicate how the participants reasoned their current rate of alcohol use and described strategies they use to prevent its harmful health effects.

185 [Sylvia] I just thought it is not good for more my health.
186 That's really what I thought about. I thought, 'God, your kidneys
187 and my liver. What am I doing to it?' That's true. But I'd always go
188 home and drink a jug of water or you know. Even before, if I was
189 out at [my partner's] and before I left I'd have a couple of glasses
190 of water before I went.
191 I was conscious that I had to flush it out of my body. (Int. 16)

192 [James] For me, I worry, I'm in my 60s, I feel you don't want
193 to be putting your liver at risk. I'm probably losing enough
194 brain cells already, I don't need to lose any more. And you
195 know it's just commonsense things. I go the gym and I train and
196 I do weights and a lot of aerobic stuff. And I've got joints that
197 are wearing out. And the last thing I need is to be damaging

198 my system more or wearing it out any further by
199 either drugs or alcohol. (Int.15)

200 [Jonathon] I think just health and I couldn't cope with it anymore.
201 Waking up with a sore head and yeah. Yeah. I couldn't be doing
202 with it (drinking) *anymore. And I wanted to stay fit and*
203 the game had changed and semi-professional.
204 So you had to be fit basically. So you couldn't drink. (Int. 17)

Participants in these excerpts have drawn on the 'health issue' discourse and expressed their worry about harmful effects of alcohol on their health. However, they worked to resist it and positioned themselves favourably as someone who consumes alcohol sensibly. For example, Jonathon (line 203) referred to drinking in later life as a semi-professional and described how the body changes with age and the required adjustment in alcohol consumption that follows that change ('the game had changed'). By describing their current alcohol use in positive terms, participants closed opportunities for experiencing negative positioning of an irresponsible drinker in relation to their health.

Some participants talked about change in their alcohol use in the context of medication. For example, the following excerpts illustrate how participants' current rate of drinking is determined by their medication intake.

205 [James] And I think partly both of us are on medications
206 where we're not supposed to drink very much alcohol.
207 So that's what goes through my head.
208 Even if we'd like to drink more we don't. (Int. 15)

209 [Hannah] The likes of men, I'm an asthmatic. So when I'm
210 on antibiotics or prednisone, which is the steroids and that,
211 I stay clean away from it (alcohol). (Int. 18)

212 [Sylvia] And like I say I don't get many headaches but if I do get
213 a tension headache I'll take a couple of panadol and a glass
214 of water and I won't have alcohol. (Int. 16)

James in his quote indicates that drinking alcohol for him is a well controlled practice and negotiates his drinking around health reasons. He notes that even he would like to drink more; he doesn't (line 208) because of his medications. In a similar manner, Hannah and Sylvia also take firm positions of a good drinker in their accounts.

Positive subjects' positions taken by participants when drawn on this discourse were challenged by the interviewer by asking what would happen if the participants were part of a social setting while on medications? The participants commonly reported that it would be an 'exception to the rule' and drew on the 'social life' discourse. In negotiating their drinking in that context, they justified their (potential) alcohol use with social reasons over health concerns. The following excerpts illustrate the importance of the social setting for alcohol use among participants.

215 [Carl] But there I guess there could be circumstances perhaps
216 when I was taking some medication which had a label on it
217 which said, you are advised to not drink alcohol when you
218 are taking this medication or something and it's a special
219 occasion and I might say, oh I'll just have a shandy, you know.
220 Feeling a bit of beer and lemonade probably won't matter. (Int. 8)

221 [Bridget] I don't think I would worry too much just for the
222 odd occasion.
223 And hope for the best. (Int. 7)

224 [Doreen] Oh, I might at a wedding or Christmas Day or
225 something – you know - the odd thing.
226 But I wouldn't drink every night, like I do now. (Int. 12)

Participants in these excerpts positioned themselves favourably and justified their alcohol use with social reasons and not with intentions of getting drunk. They have drawn on the 'social life' discourse to rationalise their alcohol use and indicated the importance of social context on their drinking behaviours. Participants described drinking in the social setting as acceptable if perceived as sensible, even when the participants' health may be compromised, as acknowledged by Bridget (line 223).

To support their position of a good drinker when in need of medication, some participants talked about vague instruction or lack of it given by health professionals. For example, in the following excerpt William justifies his alcohol use when on medications with vague instructions written on it. In a similar manner, Bridget avoids negative positioning by talking about lack of information on medication in regards to her drinking.

227 [William] I don't take any conscious notice of it (instructions).
228 It's not specific enough.
229 What does 'restrict' mean? One bottle? Two bottles? Six? (Int. 13)

230 [Bridget] Yes, I do have cholesterol tablets and one for my throat
231 which I have problems with. I get too much acid, so I have to
232 take that. But apart for that, for arthritis
233 I have to take Panadol or Neurofen.
234 [Interviewer] Ok then. And do you know if any of those
235 medications require you to refrain or limit (alcohol)....
236 [Bridget] It doesn't say so. (Int. 7)

In these excerpts participants acknowledged their health issues and expressed awareness of a need for limitations of alcohol use that may apply when using medications. However, they worked to justify their drinking in this context and resisted negative positioning of one who drinks alcohol harmfully. While participants did show an understanding that alcohol use is harmful and has many adverse consequences, the 'health issue' discourse was actively resisted by participants.

4.5. A 'problem' discourse

Participants talked about adverse consequences of drinking. The 'problem' is identified as discourse as participants commonly expressed understanding of the negative effects that excessive and binge alcohol use may have on drinkers, their families and wider communities. Some descriptors and images used by participants who drew on this discourse were: 'a social issue', 'domestic violence', 'hospitalisation', 'motor vehicle accidents' and 'a burden to societies'. However, participants actively resisted to this discourse in order to avoid negative positioning of a problematic drinker. The following section outlines how the participants used the 'problem' discourse and the ways they resisted experiencing negative positioning in that regard.

4.5.1. Young people and New Zealand binge drinking culture

Participants frequently talked about alcohol use as a problem of young people and their binge drinking behaviours. They used the 'problem' discourse to construct young people's drinking as harmful and problematic. Participants referred to the visibility of their binge drinking behaviours and the media attention it attracts. Constructing young people drinking negatively and as a problem, allowed participants to appear favourably. For example, the following excerpts illustrate how some participants constructed alcohol use as a problem of young people.

237 [Bridget] Even up this road on a Saturday night up till about 2 in
238 the morning you get kids wandering out in the middle of the road
239 and they're all off their trolleys. You know. About two Saturdays
240 ago I woke up about 2 o'clock in the morning and I thought,
241 'What on earth's that noise?' Had a peek out the window and there
242 was just a whole crowd of kids walking up the middle of the street
243 doing a haka. I called my son in (...) and he said, 'Mum, You've got
244 to get out of there.' I said, 'I don't want to. I like my house.'
245 They're not bad though they're pretty harmless. They don't do any
246 damage but I thought, 'Oh. It only takes a car to come flying around

247 the corner and they'd all be skittled.' And that's a shame. (Int. 6)

248 [Carl] And I suppose there are very young people drinking and
249 you hear about 12 year olds and 13 year olds drinking and
250 those are all issues and I am sure if I thought about it longer
251 I'd think of some others. (Int. 8)

In these excerpts both Bridget and Carl constructed young people's drinking negatively and referred to the visibility of their drinking behaviours and media news when talking about it. Carl specifically talks about the age of young people (line 249) who engage in alcohol use as problematic, which works to support his claims that alcohol use is a problem of youth.

While participants frequently talked about the visibility of negative effects of drinking alcohol in relation to the younger population and actively resisted to the 'problem' discourse, some participants constructed alcohol use as a problem associated with any age. In the following excerpts Bonnie and Paul indicated that visibility of a problem does not determine the problem.

252 [Bonnie] Not necessarily (problem of young people). *I think just*
253 a lot more visible. Especially seeing these things on TV. And you
254 have to ask how many - I am sure there are people of different
255 ages. A lot of men middle aged who drink heavily and drive home
256 and possibly are much more dangerous than these young
257 kids who are vomiting in (...). I mean - I don't know but if
258 things are a bit too easy to latch on to one highly visible group.
259 I mean I've seen plenty of older people
260 who drink far too much and become rather ugly (Int. 5)

261 [Paul] Although I must admit I've gone to pick the kids up for
262 instance at night time when they've been out and you go through
263 the square and there's lots of people walking around the town at
264 one - two o'clock in the morning and um yeah I don't know. I don't
265 think it's worse than it was. I just think it's more out in the open and
266 that may be where the problem is. (Int. 10)

Bonnie and Paul in these excerpts do not resist this discourse. They talk about media focus on drinking behaviours of young people, which takes attention from problematic alcohol use of other population groups. Bonnie in her account (lines 259-260) constructs older people's drinking as a problem.

Participants frequently talked about drinking as a problem of young people in relation to New Zealand's drinking culture. For example, April and Sylvia in the following excerpts talk about young people drinking as a problem and draw on cultural images of the current drinking culture. In these accounts youth drinking is constructed as a social issue, guided with peer pressure and the identity of a cool person that motivates young people to drink excessively.

267 [April] The trouble is, when you get down to it, is the culture
268 of New Zealand is to get out there and get drunk. And I think
269 you've got to change that, to give people something else to.
270 You can't just ban alcohol, you've got to give them something else.
271 Because in New Zealand it's cool to get drunk. (Int. 3)

272 [Sylvia] They can't just have one and be social. They've got,
273 there is something that's happened in society that's caused
274 them: 'I've got to drink. I've got to drink. I've got to drink.'
275 Now I've had my overseas students come home and say to me,
276 they've heard their friends on a Monday, at college, say that
277 they drink that much because they've got to drink more than
278 that friend and they have it as a game. (Int. 16)

To support the credibility of the speaker's positioning in relation to the negative construction of young people's binge drinking culture, some participants contrasted cultural images of normative behavior of youth drinking in New Zealand with images of youth drinking in other cultures, such as German and Norwegian, where drinking was presented as acceptable and a part of everyday life. For example,

279 [Sylvia] I've hosted students from Germany and Norway. They
280 are allowed to drink alcohol in these countries from the age of 18.
281 They just have a drink. They are not interested in this culture
282 of binge drinking. Now they did say they'd see some of them in
283 their countries too, but not to extent they saw when they were
284 living here in New Zealand. (Int. 16)

Some participants referred to the problematic alcohol use when reflecting on their past experiences. For example, Earl in his account draws on cultural images of the 'six o'clock swill' to describe his past drinking behaviours. This comparison works to position Earl favourably, as his current alcohol use is not as bad as it was in the past (line 291).

285 [Earl] They used to go straight to the boozing, drink until six
286 o'clock and take home a couple of flagons. She (wife) was brought
287 up in that era, her mother and father both used to drink a lot and of
288 course, when the hotels weren't open in those days, they would all
289 drink at home on the weekend, you know, at the Sunday schools and
290 everything. Anyway, as I say, that was the old culture then.
291 I haven't drunk like that for years. (Int. 2)

In a similar manner, Paul and James also talked about their past experiences and referred to problematic drinking as a young age phase. Binge drinking, as illustrated in the following excerpts, is constructed as usual and used as an extreme case formulation ('most teenagers go through that', James, line 302) implying its normality. For example,

292 [Paul] I suppose as I said before, when I was at varsity I
293 suppose we had our experiences of binge- we didn't call it
294 binge drinking then. We just called it going out on the grog.
295 I'd call it a rite of passage. I suppose it sounds a bit awful but
296 I suppose you grew out of it. (Int. 11)

297[James] We're not binge drinkers at all. For me that's sort of
298 getting into the level of 6 or more standard drinks on one
299 occasion. It's not something we do. But having said that when
300 I was younger, certainly. I'd get out with my mates and we'd have
301 a lot more than 6 standard drinks.
302 Most teenagers go through that. (Int. 15)

James and Paul in their accounts acknowledged that binge drinking is part of the New Zealand drinking culture, but they construct it as a 'rite of passage' and the 'teenagers' phase' suggesting its normality. While these participants are aware of adverse effects of alcohol use and position young people as engaging in harmful drinking behaviours, they also resist the 'problem' discourse by constructing it as a phase as their current drinking behaviours are not harmful or problematic.

Participants who have drawn on the 'problem' discourse commonly constructed young women drinking as a rising issue. These constructions indicate gender expectations associated with normative behaviour when it comes to drinking in New Zealand. The following quotes illustrate the participants negative positioning of young women drinking. David's account, for example, described differences in expected gendered drinking practices in New Zealand and potential harmful consequences of such drinking.

303 [James] My wife shakes her head, she sees young teenage girls,
304 and we're talking 12, 13, 14 and they're drunk in public
305 streets, staggering around. And she says, 'If nothing else',
306 she says, 'there's so much at risk.' (Int. 15)

307 [David] You know, as a guy, a guy is a guy. He will go out
308 and drink and if there's a bit of skirt on the side, well, you know,
309 he will chat them up. That's the male and female thing, but
310 the girls get trashed and don't know what's happening. (Int. 6)

Participants in these accounts recognised gender-based patterns of drinking. While some participants constructed young women drinking as a rising issue, they did not refer to drinking in later life to be a gendered-based practice. A common description of drinking with spouses and partners was noted in the transcripts, without reference to gender expectations associated with their alcohol use.

4.5.2. Being responsible

Participants frequently talked about their current drinking behaviours as responsible and controlled and not being harmful either to themselves, their families or wider communities. They commonly drew on the 'functional drinking' discourse to construct their drinking behaviours positively and actively resisted the 'problem' discourse. This works to present their alcohol use positively and avoid the negative positioning of a problematic drinker.

To support their positive positioning of the controlled drinker, participants talked about their drinking behaviours in the context of driving. The following excerpts illustrate how participants constructed their current drinking behaviours in the context of driving and positive positions the speaker claimed when drew on this discourse.

311 [Vicky] We tend now to either get dropped off to where we are going
312 and get taxied home or one of us doesn't drink or someone comes
313 and picks us up. One of the kids or someone we're with who hasn't
314 drunk. We have a couple of people who can't drink or don't drink,
315 so if we're with them they obviously become the driver. (Int. 1)

316 [Carl] It's probably the main reason I perhaps drink one or two
317 rather than three or four. But even if I wasn't driving, I probably
318 wouldn't go past the three or four.
319 But it probably makes some difference, yes. (Int. 8)

320 [Paul] I don't mix drinking and driving.
321 If I'm going to drive I don't drink. (Int. 11)

322 [Doreen] Because I knew that [friend] had to drive home for
323 a start and I would never encourage her to have another one.
324 And it was a nasty night, too.
325 So we just both said, 'No, thanks.' (Int. 12)

In these excerpts Carl (line 316) and Doreen (lines 322-323) indicate that driving determines the rate of their drinking. These positive constructions of alcohol use work to present their drinking behaviours as socially acceptable. Firm positions of a controlled drinker in the context of driving were consistent across participants. They referred to their drinking as responsible and controlled, and positioned themselves favourably as drinkers who understand the risks of drunk driving. This pairing relates to HPA messages promoting safe drinking when driving (HPA, 2014). For example, the following excerpts illustrate positive constructions of a controlled drinker, which are used to resist the 'problem' discourse.

326 [Bridget] I hadn't had enough to do any damage. But it's always
327 at the back of my mind, if someone offers me a drink and I've got
328 the car I usually say no, I'm driving.
329 That seems to be these days alright. People accept that. (Int. 7)

330 [James] I just have that limit if I'm going to be driving I'd
331 never drink more than one drink. It's just sensible. So people
332 are happy with that. It's not as much of an issue as it was
333 20 years ago. You'd get a lot of pressure to drink.
334 I don't find that now. (Int. 15)

335 [Rose] Because I like a wine with my dinner. And I didn't have
336 to drive. I thought I'm not going to drive. If (…) and I were
337 paying - well hell, they owe me for all the times I've driven
338 them, you know. I don't know,
339 I suppose it's our New Zealand way of doing things. (Int. 9)

Participants in these accounts described their controlled drinking in the context of driving to be acceptable in society and differentiated it from peer pressure when it came to drinking when they were younger. They have commonly drawn on cultural images of reciprocity, as indicated by Rose (lines 337-338) when it comes to being a sober driver in relation to established normative behaviour for drinking in the social setting. Constructing their drinking behaviours positively participants actively resisted the 'problem' discourse.

Adverse effects and consequences of drinking are commonly acknowledged by participants. However, they generally resisted to the 'problem' discourse and worked to avoid being positioned negatively as a problematic drinker. They constructed alcohol use as a problem of young people and supported their claims with a visibility and media focus on their drinking behaviours. This worked to shift the blame of problematic drinking to others, which allowed participants to appear favourably. The participants' drinking behaviours were consistently constructed as positive and controlled and being harmless to themselves, their families and communities. They referred to their drinking as a controlled practice when talking about drunk driving, which works to allow participants to use alcohol without feeling that their behaviours are harmful or of concern to others.

. 4.6. The links between discourses

The participants commonly drew on most or all of the identified discourses in their talks about alcohol use. The above results have illustrated several examples of how these discourses were linked and work together. For example, the participants consistently positioned themselves as positive alcohol users. They drew largely upon positive construction of alcohol use presented in the 'social life', 'drinking to relax' and 'functional drinking' discourses to construct their drinking behaviours as socially acceptable. Use of these discourses enabled them the position of a good and controlled drinker; one whose alcohol use is an appropriate response to the relevant context.

The positive position of a good and controlled drinker was challenged once the interviewer introduced negative constructions of alcohol use by asking about adverse consequences of drinking alcohol. This allowed for only temporary disruption in consistent subjectivity offered by the participants. Participants had to work harder in these instances and conflicting discourses and subject positions were negotiated. To secure their positive positioning the participants used two strategies; they either used the negative discourses to position others as a bad drinker or they brought back in the positive discourses to position themselves positively. For example, the participants used the 'problem' discourse to construct youthful (binge) drinking as problematic. This allowed the participants to be positioned favourably as a drinker whose alcohol use is not harmful or of concern to others.

A further example is the use of the 'social life' discourse to resist the 'health issue' discourse. Use of the positive construction of alcohol use in the 'social life' discourse allowed the participants positive positioning within negatively described alcohol use in terms of its adverse health effects. For instance, Doreen in her transcript takes the position of a person who would stop drinking if alcohol would negatively affect her health. However, she also negotiated drinking during social events and reasoned it with social facilitation, and then returned to a firm position of someone who would stop consuming alcohol if required for health reasons. In a similar manner, Carl negotiated his drinking in the context of a (potential) health issue and returned to the consistent position of a person who takes care of his health in relation to alcohol use.

340 [Doreen] Oh, I would definitely not drink. No I'd rather
341 stick around to see my grandchildren grow up. Oh, I might at
342 a wedding or Christmas Day or something - you know -
343 the odd thing. But I wouldn't drink every night, like I do now.
344 If the medication was going to keep you alive or stop you
345 from getting some illness, you'd be foolish (to drink). (Int. 12)

346 [Carl] Um… I don't think that (stop drinking) would be an issue
347 for me but it could depend on the circumstances. That's a hard
348 one to be adamant about to be honest. If I had liver disease
349 and knowing what I know about the demands that metabolising
350 alcohol places on the liver, I would not drink full stop never. (Int. 8)

The results of the 'health issue' discourse indicate how people are able to resist by a health discourse and easily replace advice with their own version of themselves.

4.7. Summary

The interpretative accounts presented enabled the research questions of this study to be answered. These accounts are descriptive, because the identified discourse and examples are presented, as well as explanatory, when links between discourses are made giving them the sense of a context. The interpretative accounts allowed the researcher to identify how socially available discursive resources are used by the participants to account for their alcohol use in the particular social context (e.g. what was the social function of the account that is being offered at any one moment) and the subjects' positions provided by these accounts. The explanatory accounts allowed for identification of the ways in which the participants negotiated their positions in instances when a coherent subjectivity (e.g. a position of a good and controlled drinker) was challenged by the interviewer.

The results indicate that participants hold two distinct and contrasting views on alcohol use. They consistently portrayed drinking alcohol as positive, when talking about their drinking behaviours, and negative in relation to other people drinking. In positive terms, drinking alcohol is something that the participants use for sociability. To construct their drinking behaviours positively they have drawn on the 'social life' discourse to construct alcohol use as an integral part of social events. Participants justified their drinking with appropriateness of the context and tradition embedded in their social lives. They emphasised the importance of

social aspects that come with drinking and indicated that alcohol use offers benefits of social setting and allows them to feel included in a group. They used this discourse to claim the identity of a social person and one who has friends and attends social events. Using alcohol for these reasons they presented as socially acceptable and constructed drinking alone and for reasons of getting drunk negatively.

Findings indicate that the participants use alcohol as a means to relax and wind down at the end of the day or after work. They drew on the 'drinking to relax' discourse to construct their alcohol use positively and claim an identity of a good drinker; one who drinks for relaxation and not with intentions of getting drunk. Participants constructed their alcohol use for reasons of relaxation positively, as a behaviour associated with home environment and the evenings. Talking about alcohol in these positive terms allowed participants to present their alcohol use for reasons of relaxation as acceptable.

This study found that being in control of alcohol use and not displaying negative drinking behaviour was important to the participants. They drew on the 'functional drinking' discourse to construct their alcohol use as a controlled and regulated practice. Alcohol use was presented as being drunk by choice and therefore implied control over one's actions. Being able to drink alcohol in such a way they associated with non-dependency. Participants claimed an identity of a controlled drinker and avoided being perceived negatively as an alcoholic and being alcohol dependant. This allowed for identification of social location of their drinking behaviours in relation to stigma that is associated with alcoholism in New Zealand.

The positive view on alcohol use was contrasted with adverse effects of drinking on human health. The participants expressed awareness of a variety of diseases that alcohol use may cause. They drew on the 'health issue' discourse to construct alcohol use negatively as an issue for heavy and excessive drinkers and did not identify with it. They claimed an identity of a healthy drinker; one who drinks in moderation and takes care of his drinking and health. Constructing alcohol use in such a way worked for participants to resist being positioned negatively. Participants emphasised the health

benefits of moderate alcohol use and documented the power of public discourse on benefits of drinking in moderation. This positive positioning was challenged in talk on alcohol use when in need of medication. In this instance, the participants commonly drew on the 'social life' discourse to resist the negative position of an unhealthy drinker; one who puts his health in danger. They reasoned their drinking in social terms over health concerns and documented the importance of the social aspects of drinking on the participants' alcohol use.

The results show that the participants are aware of the adverse effects and consequences of drinking. They drew on the 'problem' discourse to construct alcohol as a problem - a societal issue and a burden. They used this discourse to position young people and their binge drinking behaviours negatively. This shift of problematic use of alcohol to *others* ensured participants' positive positioning of a responsible drinker; one whose drinking is not harmful or problematic. Participants constructed binge drinking as consistent with the current New Zealand drinking culture and implied to normality of this behaviour as a young person's phase. Contrasting their past experiences with their current drinking rates allowed participants to be positioned favourably**.** Findings also indicate that participants did not refer to alcohol use as gender-based practices at their age. However, when drawing on the 'problem' discourse, some participants constructed young women drinking as a rising issue, which suggests that there is stigma associated with public drinking by women.

CHAPTER 5

DISCUSSION AND CONCLUSION

The aim of this study was to explore contemporary understandings of alcohol use among older people in New Zealand who use alcohol. This was done by using qualitative methods to investigate reasons for drinking alcohol in later life and meanings that older people associate with it. Identification of discourses that participants drew on to construct their drinking behaviours and the subject positions that were provided for the participants in the use of these discourses allowed answers to the research questions of this study. Taking into account that there is a lack of qualitative research on alcohol use among older people, both in New Zealand and internationally, further qualitative research is needed to provide more insight into drinking behaviours in this population group. This study was conducted because alcohol use among older people in New Zealand has been identified as a growing issue and contributes significantly to the economic burden on society.

The participants in this study constructed alcohol use by using socially available discursive resources. The dominant discourses were identified by examining the talk about alcohol use to find the common places, terms and images that are consistently used together to construct alcohol use as a different object for different purposes. The participants drew upon a range of identified discourses that were labelled: 'social life', 'drinking to relax', 'functional drinking', 'health issue' and 'problem', to construct alcohol use or justify their drinking. In addition to constructing alcohol use as an object, the use of these discourses allowed different subject positions for the participants. For example, the common use of the positive discourses, labelled as 'social life', 'drinking to relax' and 'functional drinking', provided consistent subject positions of a good and controlled drinker. Additionally, the participants used negative discourses, labelled

'health issue' and 'problem', to condemn alcohol use of others, which allowed them favourable subject positions.

5.1. Alcohol use as discussed by older people

Results of this study indicated that participants held two consistent positions when it came to alcohol use. Participants consistently constructed alcohol in positive terms when talking about their own drinking behaviours and negatively in relation to other people's drinking. Older people in this study constructed their drinking behaviours through context and through places where they usually drink alcohol. Participants commonly reported drinking for social reasons and to relax at home or a party with friends and family. This suggests that an appropriate place for drinking for older people is somewhere private, which adds to the image that drinking in this population is invisible and therefore not considered a problem.

Consistent with the previous research, findings indicate that older people in this study drink to be sociable and use alcohol as a means of gaining access to and maintaining social relationships. For example, Tolvanen (1998) in her Finnish study found that for older people drinking alcohol is an accepted part of social intercourse when consumed within limits. In a similar manner, Ward et al. (2008) and Wilson et al. (2013) identified that drinking alcohol in the social setting for older people ensures sociability and it was associated with preventing them from 'losing touch'. The importance of alcohol use and group identity for older people was also noted by Grønkjær and colleagues (2011), who in their study on Danish cultural norms in relation to alcohol use found that drinking in the social group increased cosiness and positive feelings for participants. However, the finding that alcohol use is an accepted and normal part of socialising, as suggested by Ward et al. (2011), indicates that for some older people, who are very occasional drinkers, it may operate as a barrier to their social lives.

This study found that the participants drink alcohol as a means to wind down and relax. Alcohol use was associated with taking things easy and may be counted as something that maintained the quality of later life.

Similar findings are documented by Ward et al. (2011) and Wilson et al. (2013) suggesting that for older English people alcohol use is associated with taking time for themselves and contributing to a satisfying life. Using alcohol to relax and wind down was constructed as acceptable way of drinking.

Identification of reasons for alcohol use also revealed that it was important for drinkers to present themselves as people who are in control of their alcohol use. In line with the previous research, this study documented a generally negative view on alcoholics and alcohol dependency. This finding revealed a stigma that is associated with alcohol dependency and documented social distancing from the label of 'an alcoholic'. Similar findings are noted by Macfarlane and Tuffin (2010) who in their recent study on attitudes about alcoholism in New Zealand documented that alcoholism is portrayed negatively by participants who expressed general intolerance towards alcoholics. Lay reasoning around alcoholism and alcohol dependency in New Zealand may have motivated participants of the present study to work on avoiding negative positioning of an alcoholic when discussing their drinking behaviours. This may potentially be problematic, as suggested by Wilson et al. (2013), because emphasising propriety to avoid stigma around alcohol use may cause older individuals to consider unhealthy behaviour as normal on the basis of perceived self-control.

Older people in this study drew routinely on positive constructions of alcohol use. When faced with negative constructions, as documented in the 'health issue' discourse, they used positive constructions to resist negative positioning. The participants constructed alcohol use as a good medicine and commonly emphasised the benefits of drinking in moderation. This suggests that positive aspects of health messages are taken up enthusiastically to support the positive construction of alcohol use and ensure positive subject positions. Casswell (1993) emphasised potential negative effects of this public discourse that may influence an individual to drink more. Perceived health benefits in combination with alcohol desirability may have serious consequences on a drinker. She also raised concern that this public discourse may decrease the chances that the effective population focused policies will be implemented. These concerns

are warranted with a prevention paradox theory which suggests that as a society we experience more harm from the large group of light to moderate drinkers than we do from the more severe group that are the focus of the greatest amount of public concern (Macfarlane & Tuffin, 2010).

The negative constructions of alcohol use, as documented in the discourse labelled 'problem', were generally used to condemn alcohol use of others. Similar findings are noted by Ward et al. (2011), Wilson et al. (2013) and Tolvanen (1998). For example, Ward et al. found that older people in England consider drinking to be a new issue and that entertainment participants engaged in during their youth was not focused around heavy drinking, which they associated with public drinking behaviours of young people at present. Similarly, participants in this study described the current drinking culture as the cause of problems and have drawn on images of alcohol being a game for young people and allowing them the identity of a cool person. This process of shifting the blame to others, as suggested by Emslie et al. (2011), shows how health and health behaviours are used as identity strategies to contrast healthy, regulated Self with the unhealthy, out of control Other. In this way, the participants in the present study were able to maintain identities of a good, responsible and controlled drinker. This suggests that the participants perceive negative health messages to be only about somebody else - not the responsible, in control, older drinker.

This study confirmed previous findings that older people may reason their alcohol use around social and moral terms, rather than health considerations, in order to minimise the opportunity to view health risks being outweighed by alcohol desirability (e.g. Backet et al., 1994). Participants in this study used the 'social life' discourse to justify their alcohol use when in need of medication and to negotiate drinking within the negatively orientated 'health issue' discourse. This allowed them the positive identity of a good drinker defined by self-control and propriety. Similar findings are noted by Wilson et al. (2013) who found that older English people define their identities by self-control and propriety, rather than health consideration when it comes to alcohol use.

5.2. Implications of this Study

Findings of this study may inform future health initiatives in a several ways. Results indicate that alcohol is an integral part of many older peoples' lives and in a way represents social life itself. It is embedded in traditional behaviour in relation to celebrations and hospitality, and it is considered an integral part of social events. This positive view on alcohol, as documented with the 'social life' discourse, indicate that abstaining from alcohol may also act as a barrier to social life and may even produce problems for the older individual, such as social isolation and the negative psychosocial effects associated with it. Therefore, it would be impractical to encourage older people to abstain from drinking alcohol (subject to their health status).

The findings that older people don't perceive their drinking as a problem may also influence health promotion. The results of the 'problem' discourse suggest that participants did not identify with a harmful drinker or as someone who drinks to excess. Health promotion messages that would focus on excessive and heavy drinking are therefore likely to be ineffective. An approach that would target the older 'social drinker', as illustrated with the 'social life' discourse, may prove to be more effective. Messages may, for example, include personal and traditional themes that older people may identify with.

This study identified how powerful the public discourse on benefits of drinking in moderation is. However, findings support the view that what constitutes moderate drinking is ill defined by older people. Therefore, findings of this study indicate that public health initiatives should also focus on moderate drinkers. This undefined moderate drinking, in relation to volume of alcohol consumed, may potentially cause harm to a drinker. Health promotion initiatives, therefore, may include additional information on individual characteristics of a drinker and suggested quantities that these benefits of drinking in moderation are related to.

Findings of the 'heath issue' discourse suggest that alcohol desirability may outweigh health concerns when vague instructions on limitations of alcohol when used with medications are given. While this

finding may be considered as a by-product of the current investigation, it is an important one. It shows how people are able to resist unwanted positioning by a health discourse and replace advice with their own construction. Therefore, clear instructions in relation to the volume of safe alcohol consumption should be given, which may prevent older individuals from exceeding the recommended amount of alcohol. Personally perceived limitations may potentially cause harmful effects in the drinker.

While the above mentioned is concerned with implications of the current findings for practice, this study also contributes to the limited body of knowledge around alcohol use in later life.

5.3. Strengths and limitations

5.3.1. Strengths

This study used a qualitative method to investigate alcohol use among older people. The qualitative method of inquiry allowed for an understanding of the meanings of alcohol and discourses that older people draw on, and provided information on social location of their drinking behaviours. Therefore, it allowed the researcher to attend to *context* in its complexity and fluidity. This is contrary to quantitative approach, which is generally concerned with identifying a cause and effect relationship between events, without providing a deeper understanding of the phenomenon in question. While it can be argued that quantitative research may provide important information on context, it is limited in the extent to which it captures the complexity and fluidity of context on participants' own terms (Lyons & Coyle, 2007, pg. 18).

The study addressed the issue of validity in several ways. Data used in this study was collected during semi-structured interviews, which allowed the interviewer to derive information that was beyond the questions imposed to participants. In contrast to quantitative research methods, which are based on pre-recorded data collection such as structured interviews and questionnaires, this qualitative technique of data collection ensured that participants were free to challenge and correct the interviewer's assumptions

about meanings investigated by this research. Also, data collection was conducted in the real life setting in the participants' homes and avoided the pitfalls of artificial settings, such as a laboratory. This resulted in participants feeling comfortable during interviews and being prompted for additional information. For example, participants identified their homes as the most common place for drinking alcohol and they recalled certain drinking events triggered by clues in the house, such as bottles of special types of drink. Collecting data in the comfort of the participant's homes supports the ecological validity of this study.

Reflexivity was also a crucial component of this research. The researcher of the present study was engaged in personal reflexivity throughout the process of this research. She regularly scrutinised her role and position in the research and critically reflected upon the ways in which her own values, interests, beliefs and experiences have influenced the research and the findings. The researcher consulted with the project supervisor in order to get an outside opinion about how her own position may have influenced the research. For example, the researcher does not belong to the participants' age group and very occasionally consumes alcohol. She spent most of her life in Europe living in the wet drinking culture, where alcohol is consumed frequently, but in moderation, and this activity is integrated into everyday social life. This is contrary to the dry drinking culture of New Zealand, which is associated with restricted attitudes towards alcohol. This experience and positioning on alcohol use may have influenced how the findings were interpreted. Ongoing consultation with the project supervisor ensured that personal reflexivity was adhered to and assisted the researcher with keeping the results free of her personal views on alcohol consumption in later life. As Willig (2008) indicates, this ongoing reflexivity discouraged impositions of meaning by the researcher and, therefore, promotes validity.

The researcher was also aware of the need for epistemological reflexivity during the research. Taking into account that this study was based on a social constructionist framework, she consistently reflected on the assumptions about the world and the knowledge that is the basis of this epistemology, and the implications of such assumptions for the present

research and its findings. Research questions were revised and aligned with the social constructionist framework and discourse analysis methodology and method. As previously mentioned, discourse analysis methodology, being informed by social constructionist framework, determined what can be asked in the research. Methodology based on this epistemology focused on research questions on social and discursive constructions of alcohol use. Taking into account that this study aimed for an understanding of alcohol use among older people, a social constructionist framework was chosen as the most appropriate approach that allowed for investigation of social and cultural context of alcohol use, reasons for their drinking and what it meant to them.

5.3.2. Limitations

Qualitative research tends to work with a smaller sample size, due to its time constraints and labour-intensive data collection and analysis. However, small sample size enables close interaction and richness of data. Taking into account that the phenomenon that is investigated in this study is an issue for more people than are actually involved in the study, this research may confront the issue of *representativeness*. This refers to being able to generalise findings to a general population. The current sample presents specific demographic characteristics that may differ from the general older population in New Zealand. For example, the sample consisted only of community dwellers and therefore excluded older people who are institutionalised or in residential care for the ageing. The sample also included light to heavy drinkers. Views on alcohol use among non-drinkers and older drinkers in residential care, for example, may vary significantly from the views expressed by the current participants. As suggested by Willig (2008), it depends on the question that the study is aiming to answer whether we are likely to want to be able to generalise the findings to a wider population. However, while it is not possible on the basis of the findings of this study to know how many people share a particular experience, we do know that it is available within a culture or a society (Willig, 2008).

Findings of this study may not be generalised, but we may *relate* this data to the wider world. This study identified two distinct and contrasting ways of presenting alcohol among older people as presented in the 'social life' and 'it's a problem' discourses. These discourses are available among drinkers in the Manawatu and Horowhenua regions. The ‘social life’ discourse was used to construct alcohol positively as an integral part of older people's community, working and family lives, and the ‘health issue’ discourse was used to actively resist knowledge of its adverse effect. However, it is possible that older people in other regions of New Zealand or people in urban cities may have different views on alcohol use. Therefore, these findings cannot be generalised to all older people in New Zealand. However, they provide a valuable insight into alcohol use as a phenomenon in the studied population group.

The present study used a discourse analysis, which explores what characterises the social worlds people inhabit and what are the practical implications of those for people's worlds. The present study followed Willig's (2008) six steps in data analysis and did not investigate the issue of power in its wider sense. However, the power is embedded in the participant's discourses in terms of how they position themselves in relation to others (i.e. non-drinkers or other people who consume alcohol) as well as reflecting power differences in their social environment (i.e. alcohol availability and accessibility, laws and regulations). The six stages, as Willig (2008) suggests, still allowed for identification of some power discourses and how participants were positioned within those.

5.4. Future Research

Future research is necessary to contribute to our understanding of alcohol use among older people. There are many social influences that have changed over time that influence drinking practices in this population. Qualitative research that would investigate these influences would allow for a better understanding of alcohol as a growing issue amongst older people. In regards to New Zealand, studies may also include participants in the same

population group as the sample in this study, but from other regions in this country. In that case, it may attempt to solve the issue of generalisation through accumulative techniques, which can be applied within and across studies (Willig, 2008). Accumulative techniques across studies may allow us to integrate findings from a number of comparable studies with an aim to draw a wider conclusion. In that way, validity of individual findings may be enhanced.

This research identified that participants recognised gender-based patterns in alcohol use in relation to young women drinking. Similar findings are noted by Ward et al. (2011) who identified that for older people, the drinking of young women is perceived as something 'new' and 'different' to their own experiences when they were younger. However, drinking alcohol in later life, according to current findings, was not identified as a gender-based issue. Considering that this study did not focus on gender patterns of drinking, future research may investigate this complex social and cultural phenomenon among older people and provide more insight in that domain.

5.5. Conclusion

This study was conducted with an aim to contribute a contemporary understanding of alcohol use among older people in New Zealand who use alcohol. Media and research attention is focused on drinking in other populations, predominately on young people binge drinking due to a visibility of their drinking behaviours. However, an identified gap in literature and statistical data on the prevalence of alcohol use in the older population suggests that more research is required in this domain. Using qualitative methods, this study provides more insight into contextual understanding of alcohol use in later life.

Findings of this study confirmed international data on alcohol use among older people in relation to reasons for their drinking and meanings they attach to alcohol use. Findings indicate that the participants drink alcohol to be social, enhance social situations and gain social confidence, as

well as to help them relax and unwind. Participants drew routinely on positive constructions of alcohol and consistently positioned themselves as a good, controlled and healthy drinker. They commonly expressed awareness of adverse effects and consequences of drinking. They described their drinking as healthy and moderate, and constructed alcohol use as a health issue of excessive and heavy drinkers. The positive aspects of health messages in this context are taken up enthusiastically to support the positive construction of alcohol use as a good medicine, as evident in the participants' use of the public discourse on benefits of drinking in moderation. Findings also indicate that negative health messages, such as ones given with medications, are often ignored or seen as outweighed by the 'social life' positioning.

Participants in this study did not consider their drinking to be a problem. They associated problematic and harmful drinking with other people and constructed young people's drinking behaviours negatively. The finding that the participants held consistent positive positions of being a good, controlled and healthy drinker and not identified with harmful alcohol use suggests that health promotion messages that may construct alcohol use as a health issue are likely to be ineffective. Health messages that would focus on a healthy social drinker, containing clear information on a level of alcohol use related to it, are more likely to influence healthy drinking practices in this population.

There is limited research available on older people's discourses around alcohol use. This study identified several discourses in how older people talk about their drinking behaviours, which allows for a cultural understanding of alcohol use among older people in the Horowhenua and Manawatu regions in New Zealand. Findings of this study may be used to support future health promotion initiatives that aim to reduce harmful alcohol use in this population. While these findings cannot be generalised, we may relate them to other populations of older people, because in order to construct their behaviours and positions in the world, older people draw on culturally available resources that reflect their social context. Therefore, older people in different locations may draw on these or similar discourses

when constructing their alcohol use. More research is required to increase our understanding of this complex behaviour in later life.

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Appendix A: Interview Schedule

Introduction:

Are you happy for me to start recording the interview?

Thanks for agreeing to be interviewed today about how drinking fits into your everyday life. I'd like to start by getting you to complete these 3 questions about your use of alcohol. Take your time reading the instructions and answering the questions.

Part 1:

Thinking out loud about answers to Audit-C alcohol consumption measure.

Thanks. We would like to understand how people work out their answers to these types of questions.

1) Could you please tell me out loud how you worked out your answer for Question 1 (which asked how often you have a drink containing alcohol? Never, monthly or less, two to four times per month, two to three times per week, four or more times a week). What thoughts went through your mind when you were answering this question?

   Prompts:

   What sorts of things did you think about in deciding which response to tick?

   Were you thinking of your recent drinking or another time period in the past year?

   How easy was it to answer?

   Do you think there's a better / more accurate way to get this information from people?

2) Could you please tell me out loud how you worked out your answer for Question 2 (which asked how many standard drinks containing alcohol

you have on a typical day when drinking). What thoughts went through your mind when you were answering this question?

Prompts:

What sorts of things did you think about in deciding which response to tick?

Did you consider standard drinks or your usual drink size?

How did you work out how many standard drinks you have?

What were you thinking as your typical drinking day?

Were there any complications answering this question?

How easy was it to answer?

Do you think there's a better / more accurate way to get this information from people?

3) Could you please tell me out loud how you worked out your answer for Question 3 (which asked how often you have six or more standard drinks on one occasion). What thoughts went through your mind when you were answering this question?

Prompts:

What sorts of things did you think about in deciding which response to tick?

Were you thinking of standard drinks or your usual drink size?

How did you work out how often you had more than six standard drinks?

How easy was it to answer?

Do you think there's a better / more accurate way to get this information from people?

<u>Part 2. Drink size</u>

Now, I want us to focus on drink sizes.

1) First I need to ask some background questions.

   a) Could you first tell me the types of alcoholic beverages you've had in the last year, that is from _____ 2010 to _____ 2011?

      You may wish to refer to this showcard A. Are there any alcoholic beverages you have had that aren't on this list?

b) Which alcoholic beverage do you drink most of? What would be your main drink?

_____

c) Where do you normally drink _____ (main drinking place)?

_____

d) How do you normally drink it: in a glass, can, bottle…?

_____

If drinks out of a glass:

If you don't mind, could you please get the glass you most often use for drinking _____ (main drink) at home.

Do you mind if I take a photo of your favourite drinking glass. It gives us information about the types of drinking glasses that are most commonly used by people your age.

Take photo with ruler.

2) Before today, had you heard of the term "standard drink"? What do you know about standard drinks? Before today how many mls did you understand a standard drink of _____ (main drink) to be? What about of wine/beer/spirits/sherry?

3) The questionnaire asked you how many <u>standard drinks</u> you have on a typical day when drinking?

Let's pretend this water is _____ (main drink). Can you please pour me a standard drink of _____ (main drink) into your glass. Just guess the best you can if you are not sure.

If you don't mind, I'd like to **measure it**: _____ mls.

4) Could you please look at these life size photos of glasses (show glasses of their main drink only). Which glass is most similar, in terms of shape and size, to the one you most often drink _____ (main drink) from at _____ (main place).

You will notice lines on the glass; each is represented by a letter. Tell me which letter you think represents a standard drink of _____ (beverage drinks most) in that glass. **Line** _____

5) Very few people pour a standard size drinks when they have a glass of _____ (beverage drinks most) at home.

   [Point to same photo of glass]. Can you please choose the line that represents your usual drink size of _____ (beverage drinks most) at _____ (main drinking place). Try to be as accurate as possible. **Line** _____

   How many standard drinks do you think it contains? _____

   Just guess the best you can if you are not sure.

6) Can you please pour your usual drink size of _____ as you would normally have it at _____ home (place drinks most). Try to pour it just as you would normally have it. Be as accurate as possible.

   How many standard drinks do you think it contains? Just have a guess if you are not sure.

   If you don't mind, I'd like to **measure it**: _____ mls.

   *** For those who don't drink out of a glass:

Ask:

a) How do you normally drink _____ (main drink)?
b) Do you have a sample of the bottle/can you normally drink from?
c) Where on the bottle/can do you think best represents a standard drink? Measure with ruler if possible or ask if it is possible to take a photo.
d) Do you normally drink a full bottle/can at a time? If not, please indicate how much you'd drink from the bottle/can at a time. Measure with ruler if possible or ask if it is possible to take a photo.
e) How many standard drinks do you think is contained within the can/bottle (or up to that line)?

7) Here are some life-size photos of standard drinks of wine, spirits, and fortified wine in various glasses. Although I don't have a photo, a normal 330ml can or stubby of beer (normal strength) is a standard drink.

   What is your initial response to seeing these photos of standard drinks?

   I'd like you to answer these questions again (give Audit-C), this time with the photos of standard drinks as a reference.

   Wait while participant answers questions.

   Did they affect how you answered these questions the second time? How?

   Were the photos of standard drinks useful in answering these questions, particularly the questions about standard drinks?

   Did you answer any of the questions differently?

Part 3: Places you drink

I now want to ask a couple of questions about the different locations that you drink alcohol.

1) I want you to think carefully about all the places you drank alcohol in the past year, that is, between _____ and _____. Can you please tell me all these places?
   _____
   _____
   _____
   _____

2) Here is a list of typical places that people drink alcohol (showcard B -A2.01 from NZADUS). Can you let me know all the places on this list that you drank alcohol during the past year? Are there any other places you can think of that you haven't already mentioned?

Part 4: Stories of drinking

1) Now I'd like you to tell me the location that you drank at most frequently during the last year: _____.

   I'd like you to remember an actual occasion when you drank at this place, perhaps the last time you drank there or a particularly memorable time that you drank there. Can you please tell me about that drinking occasion from beginning to end? Include as much detail as you can – about the occasion, who you were drinking with, what you were drinking, how much you were drinking, the reason for drinking, and so on?

   Pause. Give time to speak.

   Possible prompts:
   You might like to start with the first drink. How did that come about? Were you interested in having a drink? Who poured it?

   What happened next?
   And after that?

   When was this? What time of day?
   Was it for a particular occasion?

   Who were you drinking with?

   What did you drink? Beer, wine, spirits, something else? What was the size of each drink? How much (of each type of drink) did you drink? In total?

   Can you tell me the reasons you drank on that particular night/evening/afternoon/etc?

   How did alcohol enhance or take away from this occasion? What were positive and negative effects of drinking during this occasion?

Did anyone encourage or discourage you to drink on that occasion? Can you describe what happened? What did you think of that?

Did you use any strategies to control or pace your drinking on that occasion? What did you do?

Did you feel tiddly, intoxicated, or drunk on that occasion? Can you tell me more about that?

On that occasion, were there any reasons that you felt you shouldn't drink? You should limit the amount you drink? You should drink more?

How did this drinking occasion end?

2) Thinking of the past year, I'd like you to remember the time you drank the most alcohol on one occasion? Once you have thought of this occasion, let me know where this occurred? Can you tell me about that occasion from beginning to end – as many details as you can remember?

Pause. Give time to speak.

Possible prompts:

How did it start? You might like to start with the first drink. How did that come about? Were you interested in having a drink? Who poured it?

What happened next?

And after that?

When was this? What time of day?

Was it for a particular occasion?

Who were you drinking with?

What did you drink? Beer, wine, spirits, something else? What was the size of each drink? How much (of each type of drink) did you drink? In total?

How often do you drink this amount?

Can you tell me the reasons you drank on that particular night/evening/afternoon/etc?

How did alcohol enhance or take away from this occasion? What were positive and negative effects of drinking during this occasion?

Did anyone encourage or discourage you to drink on that occasion? Can you describe what happened? What did you think of that?

Did you use any strategies to control or pace your drinking on that occasion? What did you do?

Did you feel tiddly, intoxicated, or drunk on that occasion? Can you tell me more about that?

On that occasion, were there any reasons that you felt you shouldn't drink? You should limit the amount you drink? You should drink more?

How did this drinking occasion end? What stopped you drinking?

3) Now I'd like you like you to choose another location and to remember a time you were drinking at that place. (Otherwise select one myself). Again I'd like you to tell me all the details of that drinking occasion from beginning to end.

Pause. Give time to speak.

Possible prompts:

How did it start? You might like to start with the first drink. How did that come about? Were you interested in having a drink? Who poured it?

What happened next?

And after that?

When was this? What time of day?
Was it for a particular occasion?

Who were you drinking with?

What did you drink? Beer, wine, spirits, something else? What was the size of each drink? How much (of each type of drink) did you drink? In total?

How often do you drink this amount?

Can you tell me the reasons you drank on that particular night/evening/afternoon/etc?

How did alcohol enhance or take away from this occasion? What were positive and negative effects of drinking during this occasion?

Did anyone encourage or discourage you to drink on that occasion? Can you describe what happened? What did you think of that?

Did you use any strategies to control or pace your drinking on that occasion? What did you do?

Did you feel tiddly, intoxicated, or drunk on that occasion? Can you tell me more about that?

On that occasion, were there any reasons that you felt you shouldn't drink? You should limit the amount you drink? You should drink more?

How did this drinking occasion end?

4) Follow up questions.

   In the past year, from _____ to _____:

   Who did you drink alcohol with? (Use locations to prompt)

   What occasions did you drink alcohol? (Use locations to prompt)

   What are all the reasons you drank alcohol? (Use locations to prompt)

Part 5: Moderate and excessive drinking

I now want to know your views on drinking.

1) In your opinion, what is drinking in moderation? Prompt: Describe/give me an example of drinking in moderation.
2) In your opinion, what is excessive drinking? Prompt: Describe/give me an example of drinking in excess.
3) In your opinion, what about binge drinking? Prompt: Describe/give me an example of binge drinking.
4) Are you aware of any NZ guidelines about how much people should drink? What do you know about these guidelines? What about how much older people should drink? Do you think guidelines should be different for people of your age and older?
5) Do you think you drink within the guidelines?
6) Has your drinking changed as you've got older? In what way? Why?

Part 6: Drinking and health

I now want us to focus on drinking and health.

1) What do you know about alcohol's effects on health? Tell me what you know.
2) Do you know of any medical conditions which require people to stop or reduce their drinking? Do you have any medical conditions which require limited intake of alcohol?
3) In the last year, can you think of any occasions that you drank alcohol when a medical condition means you shouldn't have? Or when you thought it wouldn't be good for your health? Tell me about one such occasion. What motivated you to drink on that occasion?
4) Have there been occasions during the last year that you drank alcohol to help a health condition? Can you tell me more about this.
5) Do you sometimes drive a car or some other type of vehicle after you've consumed any alcohol? How do you know if you are ok to drive? How do you figure out how much alcohol will enable you to remain in the drink-driving limit?

Part 7: Drinking and medications

Now, I'd like us to talk about drinking and medications.

1) Do you take any medications? What medications are these? [Participant may wish to get boxes or containers]. Write them down or take photo.
2) Do you know if any of these medications require you to refrain from drinking while you are taking them?
3) Do you always follow this advice? Can you tell me about an occasion that you drank anyway? Tell me about this occasion and any reasons you drank.

Part 8: Alcohol reform

Finally, I'd like to hear your views about the alcohol reforms that were discussed in parliament last year. This discussion was in response to the Law Commission's review of New Zealand's alcohol laws.

1) Did you follow this in the news at all? What did you think about it?
2) Do you think that any laws should be changed with regard to alcohol - its sale, taxation, purchase, or the drinking age?

Well we've come to the end of the interview now. I'd like to thank you very much for the thoughtful comments you've made during the interview. We will send you a written copy of this interview soon.

Appendix B

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PUKENGA TANGATA

How are we drinking?
Exploring the everyday use of alcohol by older people.

INFORMATION SHEET

You are invited to participate in a study about older people's drinking.
You have been sent this invitation because you indicated an interest in being interviewed when you completed the NZ Longitudinal Study of Ageing questionnaire.

This study aims to better understand when, where, with whom, how much, and why older people drink alcohol. In other words, how drinking fits into our everyday life. This study also aims to find out older people's perceptions of moderate and excessive drinking, and the health effects of drinking alcohol.

This research is being conducted by Associate Professor Antonia Lyons, Associate Professor Christine Stephens, and Dr Rachael Pond from the School of Psychology, Massey University.

Who is able to take part?
We are seeking participants who:

- ★ are about 55 to 75 years old
- ★ are living independently (i.e., not in a nursing home or hospital)
- ★ have drunk alcohol occasionally or regularly in the past year
- ★ are willing to participate in an interview, and have this interview sound recorded
- ★ are comfortable conversing in English.

What will you be asked to do?
You will first complete a brief questionnaire about your consumption of alcohol. Directly afterwards you will be interviewed about your drinking in the past year - including when, where, with whom, and why you drink alcohol. You will also be asked about drink sizes, your definition of moderate, binge, and

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excessive drinking, and about health effects of drinking. Completing the questionnaire and interview will take approximately one hour.
The interview will be sound recorded. As long as you agree, it will take place in your home.
We don't anticipate any significant discomfort arising from the interviews. However, if you felt uncomfortable discussing yours or other people's drinking, details of where you can get support are attached to this information sheet.

What happens to the information you provide?
The sound recording from your interview will be converted into a typed interview transcript. This interview transcript and your questionnaire data will be anonymised (names and personal details removed) so that you cannot be identified. Your name and contact details, which are required only to provide you with a summary of the results, will be kept separate from your questionnaire and interview data. No material which could personally identify you will be included in any reports or publications resulting from the study.

The anonymous data will be analysed by the researchers named above, with the help of participants who volunteer to become researchers in the project (you will be included in this invitation). Once the analysis is complete, you will be posted a summary of the findings.

Only the researchers named above will have access to any data that could identify you. During the analysis, all data will be stored securely. After the project is completed, the sound recordings and interview transcripts will be archived in the School of Psychology's data storage facility for five years, after which it will be securely destroyed.

Participant's Rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- withdraw from the study any time before the data is analysed (April/June 2011);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- ask for the audiotape to be turned off at any time during the interview;
- be given access to a summary of the project findings when it is concluded.

Project Contacts

If you have any questions or comments about the project please contact Rachael Pond on (06) 356 9099 x 2047 or email R.L.Pond@massey.ac.nz.

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application 11/04. If you have any concerns about the conduct of this research, please contact Dr Nathan Matthews, Acting Chair, Massey University Human Ethics Committee: Southern B, telephone 06 350 5799 x 8729, email humanethicsouthb@massey.ac.nz.

Alcohol-Related Services

If you feel any discomfort discussing your drinking during the interview, or you wish to contact a service to talk about your drinking anyway, please feel free to contact:

Alcohol Drug Helpline
A confidential, free phone service for people with questions about their own or someone else's drinking or drug use. Provides information, brief intervention and referral services, nationwide.
Phone 0800 787 797 (10am - 10pm, 7 days), email ada@adanz.org.nz or visit www.alcoholdrughelp.org.nz

Best Care (Whakapai Hauora) CharitableTrust, Palmerston North
Mental Health and Addiction Service providing assessment, counselling and referrals to other programmes. Has Maori worker.
Phone 06 353 1884 (8:30am - 5pm), email BCWH@rangitaane.iwi.nz or visit www.whakapaihauora.maori.nz

Te Runanga O Raukawa Whakapiki Hauora - Nga Oranga O Te Rae – PN, Feilding, Levin, Otaki
Community support for people and their whanau across the lifespan, who have an alcohol and drug problem. Kaupapa Maori perspective, but open to anyone. Has Maori worker.
Phone 06 356 4963 (PN), 06 323 6446 (Feilding), 06 368 8768 (Levin), 06 364 5121 (Otaki)
Email lesp@raukawa.iwi.nz

Visit http://www.adanz.org.nz/Services/Home for details about other services.

Appendix C

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PUKENGA TANGATA

How are we drinking?
Exploring the everyday use of alcohol by older people.

PARTICIPANT CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to participate in this study under the conditions set out in the Information Sheet.

I agree to the interview being sound recorded.

Signature: _____ **Date:** _____

Full Name - printed _____

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Appendix D

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TE KURA PUKENGA TANGATA

How are we drinking?

Exploring the everyday use of alcohol by older people.

CONFIDENTIALITY AGREEMENT FOR CO-RESEARCHERS

I ..... (Full Name - printed)

agree to keep confidential all information concerning the project titled, 'How are we drinking:

Exploring the everyday use of alcohol by older people .

I will not retain or copy any information involving the project.

Signature: _____ **Date:** _____

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