Title

How do older people normalise their drinking?: a discursive analysis of interviewee accounts

Abstract

Alcohol consumption has been linked to a wide range of social and health problems, and it is known that drinking among older age groups has been increasing. Relatively little qualitative research has examined how older drinkers make sense of their drinking practices, including how they seek to normalise their consumption when talking about it. This paper reports on a qualitative interview study with older drinkers (n=25; aged 41-89), focusing on the various discursive strategies they use to rationalise their drinking. Discursive analysis of the interview transcripts highlights four key approaches used: strategic vagueness; reinforcing responsible restraint; self-serving comparisons; and downplaying drinking as mundane practice. Taken together, the efforts made to convey drinking in moderation suggest a concern among interviewees with being regarded as a good citizen, in control of their consumption and their lives generally. Some possible implications for health promotion, and ideas for further research, are discussed.

Key words: Alcohol; older drinkers; discourse analysis; normalisation; minimisation

Introduction

Drinking behaviour is different for different groups in the UK and alcohol messaging and norms are complex, variable and open to interpretation by individuals and communities. Safe drinking guidelines are often critiqued by consumers, who apply their own subjective assessments (see Khadjesari et al., 2018; Lovatt et al 2015). While alcohol consumption is commonly associated with pleasure, celebration and leisure, evidence has grown of a wide range of physical and psychological health and social problems. The term hazardous drinking refers to consumption at levels which increases the risk of problems, including gastrointestinal disorders (especially liver and pancreatic disease), cardiovascular diseases, depression, anxiety and cancers or acute intoxication-related injuries and violence (see Griswold et al., 2018). Harmful drinking involves drinking that involves any health or social problems. Ways of talking about, and thinking about, problems from alcohol consumption are limited by discursive convergences and conflicts between practices of encouraged consumption and negative addiction discourses (Reith, 2004). The latter situate 'the addict' as radically other to the healthy, responsible drinker (Keane, 2002). Reminders to drink responsibly, without clearly defined levels of 'responsible' consumption, are prevalent in health promotion discourse and are placed on product labels as part of a voluntary agreement with the alcohol industry (Maani-Hessari & Petticrew, 2018).

Drinking alcohol can be compared with other 'lifestyle' practices such as smoking, sedentariness and (poor) diet: deemed risky within a neoliberal 'healthist' climate which emphasises personal 'choice' and individualisation of responsibility (see Crawford, 1980; Lupton, 1995). Room (2011) suggests that individual responsibility is the solution offered to citizens faced with the unregulated marketing of alcohol products within consumer societies on the one hand, and the capitalist requirement of sober, functional citizens on the other. In other words, individuals are positioned as accountable for their health-related decisions, subject to a culture of 'responsibilisation' and 'lifestylisation' where agency and self-monitoring are prescribed (e.g. Lucivero and Prainsack, 2015). Drinking is also a topic frequently introduced in healthcare settings, in routine doctor appointments, health checks and in wider settings, such as pharmacy and dental care.

As a potentially problematic practice, drinking alcohol, especially if construable as excessive, becomes something to be justified, defended, rationalised: a moral issue with implications for personal accountability and identity (see Wilson et al., 2013). When asked about their drinking practices (e.g. in health professional interactions), individuals may well volunteer information which is designed to present their consumption – and themselves – as respectable, modest or otherwise acceptable. For example, they may minimise the amount or frequency and/or present it as normative (a social phenomenon in which everyone partakes; see Denvir, 2012). This orientation to accountability is also witnessed in other health-related areas, perhaps most obviously smoking: smokers have been found to present themselves as socially responsible through practices such as not smoking in front of children or in other people's homes (see Gough et al., 2013).

While prevalence among adults in England has fallen for more than ten years, those aged 55-64 are most likely to be drinking at hazardous levels (NHS Digital, 2017). Older drinkers are the focus of this paper. Until recently, the study of drinking practices and perceptions among middle-aged and older drinkers has been neglected by researchers (Bareham et al., 2019). In the UK and elsewhere, the term 'binge drinking' is typically applied to young adults and has been the focus of ongoing research, although definitions used to categorize 'binge' alcohol consumption vary (Berridge et al., 2009), and overall consumption of alcohol in younger age groups is diminishing (Fat et al., 2018), Life limiting chronic conditions, including comorbidity (living with two or more chronic conditions), are also more common within this older demographic, and it is well established that alcohol consumption can

affect disease symptoms and management, as well as compromise the effectiveness of medicines (e.g. Bamberger, 2015). In fact, the authors have elsewhere analysed how older patients understand the impact of drinking on medication use and wellbeing (Authors, in press). So, the risks posed by increasing levels of alcohol consumption by older people, including direct impacts on health (e.g. falls; cognitive impairment), effects on existing conditions and interference with medication functions, make this population an important one for researchers to consider.

As evidence of increased drinking levels among older drinkers has emerged, researchers have begun to examine how drinking is constructed by this group. Overwhelmingly, this qualitative research has demonstrated a tendency for older drinkers to normalise their drinking (see Muhlach et al., 2018; Bareham et al., 2019 for reviews), for example by situating it within everyday contexts of relaxation, social interaction and domestic practices, such as watching television, having dinner, and reading (see Kelly et al., 2018; Khadjesari et al., 2018; Nicholson et al., 2017). In addition, older drinkers have been found to emphasise self-regulation, for example pointing to abstinence in relation to family, work and associated driving responsibilities; for example not drinking on a 'school night' i.e. during the week (e.g. Lovatt et al., 2015; Emslie et al., 2012). Interestingly, health, especially the risk of long term health consequences, is rarely mentioned as a reason for reducing or avoiding alcohol intake (Muhlach et al., 2018; Authors, in press). Some studies have also highlighted the use of comparisons with other 'deviant' drinkers, which serve to position one's own drinking as moderate: those perceived to drink for inebriation, notably younger drinkers, were often invoked (see Khadjesari et al., 2018).

Few studies to date, however, have attended closely to the discursive strategies used to construe one's drinking as normative (and oneself as respectable). Some have touched on identity and morality as relevant issues concerning drinking talk (see Denvir, 2012; Wilson et al, 2013), but there is much scope to identify more precisely the formulations people deploy when seeking to normalise or minimise their drinking levels. As Muhlack et al (2018: 2) note: 'we know little about the motivations and decision-making processes of non-problematised middle-aged drinkers'. By illuminating the repertoire of lay accounting practices, we will be able to document which issues are made relevant (identities, morality, accountability) – and how these issues are actively managed (in interviews) - and so extend knowledge about the place and meaning of alcohol in the lives of older drinkers.

Importantly, a discursive approach does not assume any direct relationship between words and behaviours, and so we will not be claiming that the accounts deployed by interviewees directly shape consumption patterns. While much qualitative research, including qualitative research on drinking, takes a descriptive, experiential approach, the focus of discourse analysis is on how talk functions in context, in this case during an interview with a researcher interested in their medication use, drinking practices and views on a proposed alcohol intervention led by pharmacists. That is not to say, however, that discourse analytic research is not useful for health professionals or health promotion specialists. Such research can be disseminated to better sensitise practitioners to lay discourse patterns, and as such they may be better equipped to manage consultations where alcohol is to be discussed. For example, dominant lay repertoires may be anticipated to permit appreciation of the context-bound nature of drinking, and how health professionals may assist or hinder people in their decision-making. This is congruent with ideas about successful health promotion, in which agency is located within context, rather than associated with abstract ideas such as lifestyle (see Marmot & Bell, 2012). So, this study aims to provide insights into the issues that older drinkers make relevant in relation to (their) alcohol consumption, and how they manage these issues discursively when addressing a third party.

Method

Participants and procedure

Interviewees were recruited to an NIHR-funded study focusing on medication use, drinking and the appropriateness of discussing alcohol consumption with pharmacists. For this paper we focus only on interview sections where individuals were asked to describe their drinking habits. The study received research ethics approval (REC reference 17/YH/0406).

Recruitment was pragmatic, aiming for a diverse sample of people who drank alcohol twice a week or more often, within the limitations of the field work time frame (March - April 2018). Recruitment was conducted within seven pharmacies in the North of England. Researchers (SM and MM) encouraged referrals through pharmacy staff and attended pharmacies at different times of day to recruit directly. The number of people approached directly was not systematically recorded. Posters and flyers about the study were displayed, placed on pharmacy counters and distributed to people waiting for their prescriptions. These asked: "Do you take medications long term? And do you drink alcohol twice a week or more?" If people answered yes to the flyer questions and were interested, pharmacy staff or a researcher provided brief information about what was involved and asked for a telephone number. A researcher then called potential participants to confirm their interest in the study and provide further information. Patients were sent a recruitment pack which included an invitation letter, a participant information sheet, and a study consent form; individuals willing to be interviewed were asked to confirm drinking status using the shortened form of the Alcohol Use Disorders Identification Test (AUDIT-C; Bradley et al., 1998). Contact details for the research team were also provided to enable participants to ask any further questions in advance of the interview. Written consent was obtained at interview and participants were given assurances about their rights, confidentiality and anonymity of their responses. Participants received a £10 shopping voucher to thank them for their time.

The 25 participants recruited are anonymised and given identifier codes which convey some simple description. For example, 19F-9 means that patient interviewee number 19 is female with an AUDIT-C score of 9. Higher AUDIT-C scores (on a scale of 0-12) indicate higher likelihood of a person's drinking affecting his/her health and may provide some context for understanding and comparing participant accounts; for example, it would be interesting to note similarities and differences in discourse presented by those with high and low scores.

Data collection and analysis

Semi-structured interviews were used because they allowed for flexibility in data collection and the production of rich narratives, which permitted analysis of how participants made sense of the topic under investigation. Interviews were conducted by two research team members in participant homes using a topic guide, which included open-ended questions on the use of alcohol in everyday life as follows:

- Can you tell me a bit about how drinking fits into your daily life? - When do you drink? What do you generally drink? Where? With whom? What do you enjoy about drinking? How has your drinking changed from when you were younger? Any downsides?
- How does drinking fit in with your medication? Do any meds alter the way you drink?
    - Ever skipped meds if you are drinking YES- Why? Consequences?
    - Drinking ever increased or decreased the effects of your medications?

    - Drinking ever affected your ability to take meds – e.g. forget?
- Do you ever use drinking to manage your condition or particular symptoms, e.g. to help you get to sleep? Manage pain? Relax? Other ways?
- Does drinking affect any of your conditions in particular?
- Overall, how would you describe your own drinking? Is there anything you would like to change or not?

Demographic information on the participants is presented in Table 1.

INSERT TABLE 1 HERE

Analysis of interview transcripts was informed by discursive psychology (Edwards & Potter, 1991; Potter, 1996; Wiggins, 20017), with a focus on how drinking is constructed by interviewees. Discursive Psychology (DP) is critical of the notion of the pre-existing self or mental states and focuses (instead) on how identities, minds and selves are constructed in discursive practices. It is concerned with issues of accountability, stake and interest, and identity construction, analysing how speakers rationalise their practices, position themselves and others, and use various devices to perform preferred actions (e.g. attribute blame). Within the DP field there is a preference for examining 'naturalistic' data e.g. conversations, rather than data generated from researcher-designed interactions e.g. interviews. Nonetheless, there are many examples of discursively-informed research which uses interview data, including alcohol studies, where the interactional nature of the interview is not examined in favour of prioritising interviewee accounts (e.g. MacFarlane & Tuffin, 2010). Although the authors recognise that interviewer input impacts interviewee accounts, the broader project focus is concerned with service user perspectives, and this study draws on DP to illuminate the interpretive repertoires and discursive strategies drawn on by interviewees concerning their alcohol intake when asked about their everyday drinking.

Onfirst reading through the transcripts, it was noted that drinking talk was predominantly oriented to present drinking as modest and situated within normative contexts. Consequently, the analysis focused on the various ways in which drinking was downgraded, contextualised and rationalised. In practice, the first author read through all transcripts closely to identify all instances where alcohol was referenced by interviewees – and indeed the interviewers. Then, taking each transcript in turn, segments referring to alcohol were coded according to the different ways drinking was constructed, for example as medicinal, social and mundane. This process generated numerous codes, which were discussed with the wider research team (all of whom had gone through each transcript) with a view to linking similar codes together, and after various meetings the team agreed on four overarching discourse patterns (see below).

Analysis

Most participants presented positive aspects of their drinking linked to pleasure, relaxation and wellbeing, as other research has noted. For example, alcohol was variously invoked as a 'treat', a way of unwinding in the evenings, and as an enhancement to dining experiences at home or in restaurants. However, such positive attributions were invariably framed within a discourse of

(relative) moderation and self-control – our participants invested much time and energy in normalising their drinking practices, regardless of drinking levels (as captured by the AUDIT-C scores) – although of note are two interviewees who self-identified as dependent drinkers, and who presented some negative aspects of their drinking. Nonetheless, most participants took pains to explain their drinking practices within the context of the normal and acceptable while downplaying any possible association with 'risky' behaviours.

Such normalisation assumed many forms, and was typically delivered without prompting by the interviewer. Notably, interviewees used phrases which minimised drinking levels but without ever specifying these ('strategic vagueness'); they emphasised self-regulation using extreme case formulations ('reinforcing responsible restraint'); they pathologised other peoples' drinking, suggesting that others drank more than them ('self-serving comparisons'); and they presented their drinking as embedded within familiar routines, and therefore unremarkable, using minimising language ('mundane practice'). These identity-protective orientations to the topic were not mutually exclusive – interviewees drew variously on two or more during the course of their drinking talk, often within a short space of time, and many used all four. Although inter-related, these discursive strategies are elaborated separately below.

Strategic vagueness

Very often our participants volunteered information which signalled their drinking as modest and unproblematic – hinting at low numbers without specifying exactly what they drank, a case of strategic vagueness (see Potter, 1996). For example, amount consumed was presented as minimal:

> *Well if we have a meal and are going to have a glass of wine it's probably only going to be half a glass of wine anyway. So it's not by the time you have finished your meal the meal has soaked it up. It's not as though we have lots.* (8M- 3: Interviewee 8, male, AUDIT-C score = 3)

There were many such references to a glass (of wine), or a bottle or can (of beer), often downgraded ('*only*…*half* a glass'), and rarely indicating the actual size of the glass. The use of 'if' at the start of this account presents consumption as occasional rather than routine, while the footing shift (Goffman, 1981) from 'we' to 'you' in the context of dining suggests a more general practice i.e. something done by others as well. This interviewee had a low AUDIT-C score (3), but similar accounts were presented by those who drank more. In the following extract, low frequency was mentioned in conjunction with low amounts, reinforcing the image of self-control, even though the AUDIT score is high (9):

> *A couple of nights a week I might have a couple of bottles of ale or a can of stout, a couple of cans of Stella.* (20F- 9)

Phrases like 'a couple' or 'a few' were used many times with reference to both amount consumed and frequency, with actual numbers rarely specified, making it difficult to ascertain how much alcohol was consumed. As well, the use of 'I might have' presents drinking as non-routine. Alternatively, when amount consumed could be read as high, low frequency was emphasised; here, the previous interviewee elaborates on her drinking practices:

> *so I would easily have four or five pints…if we're out in a pub, and I would easily have a third glass of wine at home, but I'm probably only doing it once or twice a week or certainly the wine would be once a week and the beer would be a couple of times a week.* (20F- 9)

In this case the amount indicated would exceed UK guidelines and is not presented as excessive because drinking episodes are minimised ('*only once or twice* a week…*a couple* of times').

Conversely, when frequency was high, amount consumed was often minimised:

> *Well, I would say that I'm a regular drinker but not a heavy drinker. I would say that I probably have some form of alcohol four or five times…four or five days a week. I try and have at least a couple of days off. But saying that, I mean I might have a glass of wine with a meal or a small beer, or something like that, and maybe at the weekend I might go out for a couple of pints with a friend, but that's about it. (22M- 7)*

A key distinction is clearly made between 'regular' and 'heavy' drinker, with the speaker identifying as the former. Alcohol-free days are also emphasised ('at least a couple of days off'), with amounts downplayed ('a glass of wine or a small beer'; 'couple of pints'). Again, the overall quantity consumed could be perceived as high, and there is an effort to self-present as moderate.

Drunkenness was rarely recounted, and when it did feature was contextualised with respect to one-off events:

> *well, the last time I was drunk was at the funeral about a month ago, because it was a big day. And a lot of people there. And that's the only time.* (14M-11)

Here, being drunk is normalised in light of the circumstances, with other people implicated, an otherwise unusual experience ('the *only* time'). Indeed, description of the extent of drunkenness was generally eschewed, including by the heaviest drinkers:

> *I will take it steady. So I never get drunk-drunk. I'll just have a few glasses, get a little wine glow and go to bed.* (17F-11)

Interviewees were clearly keen to display self-awareness and self-control, associating pleasure with modest amounts ('a few'; 'enough'). Overall, vague depictions of drinking practices worked to minimise quantity or frequency and thereby downplay consumption (e.g. 'a few').

In some of the extracts above, drinking is conveyed as something that could happen but which is not certain ('I *might* have…'), adding to the vagueness surrounding consumption amounts and frequency. This particular formulation of hypotheticall drinking was quite common:

> *It's only if I occasionally go to my daughters and grandkids for my lunch every so often I might have a glass of wine, a small one very small, but that's it.* (11M- 5)

> *Now if I was going somewhere, a party, and I wasn't driving or anything, I might have a couple of wines but I can't drink much anymore.* (13F- 3)

In this way drinking was conveyed as not certain or guaranteed, implying personal choice and non-regularity. Alongside, there is lots of discursive work to underplay drinking ('occasionally'; 'a small one very small'; 'I can't drink much'). References here to special occasions, such as a party, were invoked by many as situations when drinking might exceed typical levels:

> *If we go to the family, you know, to visit the family, then it could be a couple of glasses. On a very, very exceptional occasion it might have gone a little bit more than that, but I'm not – I don't drink a lot.* (15M- 5)

As above, there is a tentative quality with respect to consumption ('it could be…'; 'it might have…'), with frequency ('very, very exceptional occasion') and amount ('a little bit more') minimised. Self-regulation was also signalled by emphasising considered choices, as illustrated below.

Reinforcing responsible restraint

In contrast to strategic vagueness, sometimes interviewees were more specific, for example about amounts and times pertaining to self-control:

> *I like a Bacardi and orange. I have got a bottle of Bacardi in the cupboard and it's probably been there a year and it's probably half empty...or half full whichever way you look at it. So you can see excess doesn't come into it.* (8M- 3)

> *I would never open a bottle, it would take me ages to get through it. The same with a bottle of wine as well. (25F- 7)*

> *Box of wine lasts me a week if it's just me drinking the box of wine. If he's drinking it, a couple of days. (17F - 11)*

Taking time to finish a bottle/box suggests a drinker who is in control, one who is not interested in being drunk ('excess doesn't come into it'). Extreme case formulations (ECFs: Pomerantz, 1986) were frequently deployed ('I would *never*…') to reinforce responsibility – including in relation to type and strength of beverage:

> *I won't drink spirits. I've never drunk spirits. Because it knocks you sideways…Yeah. They're [cans of lager] not strong. It's only four per cent.* (12M-10)

> *Yes I drink, usually wine. I don't drink spirits. I don't drink beer. I have a small glass, that deep, you know, just a little round thing and it's about two-thirds full and that with a meal. (15M- 5)*

High-strength drinks (e.g. 'spirits') are avoided by some of these interviewees, who prefer low-strength drinks, again using ECFs ('*only* four percent'; '*usually* wine'). Although wine may be perceived as high-strength, the amount consumed is minimised ('a *small* glass…just *a little* round thing…two thirds full').

Sensible drinking is also linked to salient responsibilities relating to parenting, professional life and sport, with recourse to ECFs ('always'; 'never'; 'completely'):

> *I've always had kids since I was 18 though, so I've always thought there's…something could go wrong I want to be able to drive. (4M- 7)*

> *Again if I went to, say, a formal dinner at school or professionally I would have a glass of wine. But I would never, I would never let people keep filling my glass up. I'd stick to the one glass or two at the most. (15M- 5)*

> *I stopped drinking completely for about three months because I was doing a marathon, and I suddenly realised I could actually live without it, and it was just like a Eureka moment.* (6F-10)

In these examples interviewees convey self-discipline in light of their important roles and responsibilities, forgoing or minimising alcohol intake to fulfil various functions. Responsibility was also demonstrated in a related way with reference to a range of health-promoting practices:

> *I mean most days I'll have a glass or two or three of wine before bed and my husband will have wine with me or he'll have beers. I try and have like a few days where I don't have it. And if I do have it I try and flush myself out with water the next day. I drink more water and like clear my system. (17F- 11)*

In this case, where drinking levels appear high (AUDIT score = 11), there is an attempt to present oneself as nonetheless responsible, making an effort to counteract the effects of alcohol ('I try'). Here, being responsible means having concrete strategies for self-control of amount or type of alcohol consumed, or for the effects of alcohol. Beyond post-drinking compensatory strategies like hydration, other practices were cited which were designed to replace alcohol altogether:

> *Well, I don't drink every day 'cause I've done a meditation course, so I try that. And I also read, have a hot bath, get in bed, have a read to try and relax. I do try other ways. So…but yeah, I think at weekend, I suppose I use it to relax, kind of thing. I've had a busy week, just relax with a glass of wine, mm. (9F- 8)*

In this case listing is employed to emphasise a commitment to (alcohol-free) relaxation and wellbeing ('read-bath-bed…') – evidence suggests such three-part lists are effective in producing a convincing account (Jefferson, 1990). As well, weekend drinking is construed as positive (relaxing) in the context of an abstinent – and busy - week.

Finally, when asked to sum up their drinking habits, most interviewees self-categorised as moderate drinkers who avoided excess:

> *Well, I'd not say casual because it's on a sort of regular basis, but basically I can take it or leave it. I don't have to go for a drink. I don't need a drink. Just while I'm there I have a drink. Like I say, it's social.* (2M- 6)

> *[I'm a light drinker] I don't feel that I'm drinking excessively. I don't ever feel that the drink is having any adverse effect on me. And it leaves the door open for social interchange with other people.* (15M- 5)

> *Moderate, very, very moderate. And it's...it's a matter whether I feel like it or not you know if I don't feel like a drink I don't go for one.* (11M- 5)

> *I think I'm keeping it within a reasonable limit. That's my opinion anyway. But the difficulty is, what do you mean by reasonable limit? (21M - 7)*

Personal control enacted through decision rules, choice and rationality are emphasised, with the first person pronoun very much in evidence ('I can take it or leave it'), and ECFs in abundance ('I don't *ever* feel'; '*very, very* moderate'…). The last quote foregrounds the subjective nature of (self-)assessments, one of the few times flexibility in demarcating boundaries is recognised. As well as emphasising self, interviewees referred to others in order to reinforce their status as respectable drinkers, as we now discuss.

Self-serving comparisons

In the course of describing their own drinking, the participants often offered comparisons with other – more problematic - drinkers. The 'others' referred to could be known to them, for example family members, friends and neighbours who drank more alcohol:

> *I couldn't come in and think, oh, I'll have a…three glasses of wine, but everybody I know does.* (4M- 7)

> *I don't go in rounds with them [friends]. I say, 'cause they drink faster than me, I'll say, I'm staying on my own* (9F- 8)

Yeah. I mean Terry will have eight pints, seven or eight pints. And the other lad, brother-in-law, he throws it down. And he'll have double Jack Daniels. Last night I had four pints, I was happy with that. And George said are you having a double rum? I said no, I'm alright. So, I'm under control with it I think. (14M- 11)

I drink in moderation. Like my daughter, she's alcoholic. She would sit there and drink a full two crates. I've seen her drink two bottles of vodka. She's terrible. I couldn't do that. (12M-10)

So, whether the others referenced are generalised ('*everybody* I know') or singled out individually (Terry; George; 'my daughter'), they are presented as drinking more and faster, and consuming 'hard' liquor (whisky, vodka), with our interviewees adhering to set amounts despite possible peer pressure, underlining their identities as moderate drinkers. The behaviour of others is construed as extreme ('throws it down'), with amounts consumed underlined ('a full two crates'), and reported speech adding powerfully to accounts of self-control ('I'll say I'm staying on my own'; 'I said no, I'm alright').

At other times, interviewees compared themselves with more generic, pathologised others:

I mean, obviously if you drink alcohol, you tend to get light-headed, but getting light-headed is a long way from being completely inebriated and under the table. That's what lager louts do. (21M- 7)

I've got port in there, I don't touch it. Ouzo…that's been there ages. I'm not a raving alcoholic. (14M- 11)

I never kind of…I never binge drink…drank to the extent that people seem to do now. (16F- 4)

Again, it is other people who over-indulge, notably younger drinkers ('lager louts'), while the interviewees might get 'light-headed' but can exercise control ('Ouzo…that's been there ages') and could not be classified as problematic ('raving alcoholic'). The use of 'obviously' renders alcohol as inevitably causing an effect for anyone, with a footing shift (Goffman, 1981) to 'you' deployed ('you tend to get a bit light-headed') to emphasise this, and minimisation used ('a bit') which then enlarges the subsequent contrast with 'being *completely* inebriated'. In other words, a significant distinction is produced between innocent, modest effects and excessive impact. Extreme case formulations are again deployed to reinforce personal control ('I *never* binge drink'; 'Ouzo…that's been there *for ages'*).

One of the interview questions asked referred to change in drinking habits over time, and here most participants narrated a shift from a formerly more problematic drinking self to the current more controlled consumer:

I never go over the top, you know. I mean, when I was a young kid I used to get drunk, I admit. But no, I never go over the top. That's my maximum. My maximum and my minimum, yeah, I stick to that all the time, yeah. (24M- 6)

I don't drink very much at all. It doesn't bother me. Years…you know, a few years ago I'd like, at night, I'd think, oh, right, it's Monday night I'll open a bottle of wine, and I'll sit every night and have a drink. Now that doesn't bother me anymore. (13F- 3)

I think I can sometimes…it can be out of control sometimes, rarely now – whereas it used to be all the time it's rarely now. But I mean I haven't had an alcoholic drink since Sunday, so I can do without it. I'm not addicted to it I suppose. (6F- 10)

The contrast between then and now works to position the interviewees as relatively controlled: formerly high and frequent intake has been superseded by lower level regimes where excess is avoided ('I *never* go over the top') or at least relegated to rare occasions ('out of control *sometimes*, *rarely* now'), with personal judgements foregrounded ('*my* maximum'). Note the autobiographical contrasts hint at restrictions to the self-control being articulated ('*not addicted to it I suppose')*, and also the challenging nature of discussion of heavy drinking ('*I admit'*). Clearly, comparisons with excessive others, including past versions of self, work to position individuals as disciplined, upstanding citizens who do not inflict any harm on self or others.

Mundane practices

Another main way of presenting one's alcohol consumption as unproblematic was to link it with common, routine, domestic and social practices such as having dinner, watching television, and chatting to one's partner:

> *Okay, drinking is always around food, the main drink is wine. I love food, I love wine, and together they're a wonderful combination, so that's where it fits in (5M- 11)*
>
> *We generally have a glass of wine with dinner every evening. That's both myself and my wife. My daughter's now getting to the stage when she's having a glass of wine with us. (21M- 7)*

Drinking (wine) with food connotes civility, social interaction and moderation ('a glass'). Other innocuous activities are also referenced, often in the context of partners:

> *I never drink it with meals unless we go out for a meal. No, it would be 8 o'clock at night when I just sit down and watch television, read a book, whatever… I suppose [I enjoy] just sitting with my husband and having a chat and having a drink together. (9F- 8)*
>
> *So the husband will have his beers and I'll have my wine and we'll sit and watch the telly and laugh and talk about the telly and we have a nice evening. It's quite cosy just us two and the cat…Our little couple thing on the weekend in front of the telly. A bag of sweeties and a drink…But no, it seems okay to me, so…and I told him* [the pharmacist] *I don't get pickled, I just have a few civilised, as we call it, drinks together with my husband and go to bed. (17F- 11)*

Three part lists are again used to paint a picture of domesticity ('sit down, watch television, read a book…'; 'we'll sit, watch the telly and laugh…'). Drinking is thus normalised with reference to simple, everyday pleasures – nothing excessive or problematic – minimised with the use of 'just' ('just sit down…'; 'just have a few…'). It was also widely associated with relaxation once daily responsibilities had been dispensed with:

> *INT* *So what do you enjoy about drinking?*
>
> *6F-10* *The relaxation, it's like I can actually…I always say it's like a full stop at the end of a sentence. It's like my day's done. Now I can just flop down and relax.*

This association with mundane, unremarkable activities at home serves to gloss alcohol use as similarly innocuous, again minimised with the use of 'just' ('flop down and relax'). Whether at home or in pubs and restaurants, drinking was widely construed as a social activity, and therefore normative:

I think of it as just going out and it's a change to being stuck in. You go out, you have a walk round, everybody has a laugh and that's…the drink…I drink the halves of bitter because everybody's drinking. (4M- 7)

Well I drink when I go bowling. I never have more than a pint and a half or three units if you like. I usually, if I want to go out I go out but usually it's maybe another once or twice a week, that's all. Just to the local. But I never drink more than a pint and a half of alcohol…It's relaxing plus I like a chat with other people at the pub. When I'm bowling it's drinking as I'm bowling. (11M- 5)

I'm a social drinker, but when I'm social, I'm very social. When I'm social, most of my friends are drinkers, so yeah, so…and it would be bouts rather than…I'm not a reg…I don't have a drink every day. (20F- 9)

In these extracts, drinking is constructed as commonplace ('everybody's drinking') and associated with social intercourse ('a chat with other people'), fun ('everybody has a laugh') and leisure ('it's relaxing'). Nonetheless, the interviewees take care to highlight their restraint ('halves of bitter'; 'never more than a pint and a half'; 'I don't have a drink every day'), using minimising language ('just going out'; 'just to the local'), thereby avoiding any potential charges of excess or dependence.

Conversely, drinking alone was generally avoided and treated as taboo:

I enjoy a drink. I don't tend to drink a lot on my own at home. (20F- 9)

Well I don't drink at home, I don't drink on a night. On a Friday night I go out. (4M- 7)

The concept of vice was used by one interviewee to construct alcohol consumption as one practice within a spectrum of potentially problematic (but also pleasurable) activities (implicitly no better or worse) to which anyone was prone:

Everybody's got their vice. You might go home and have a glass of wine, I don't know, but you've got to enjoy… You might go home and get a kebab or whatever, or your work, you might work too much. (12M- 10)

The use of 'everybody' presents vice as normative, which the interviewee then applies to the interviewer ('You might…'); as such, drinking becomes normalised as one of many possible vices. Another way in which drinking was normalised was through citing medical endorsement:

I mean, now every year they send us for what they call an MOT, you know. And he [doctor] *says, what do you drink? And I tell him what I drink. And he never passes any comment. Because I don't…that's all I drink, I don't drink anything else, yeah. No. (24M- 6)*

I've told the doctor I drink. They say the same as me, everyone's got their own vice. If you haven't got a vice in life we're all walking about like saints. (12M- 10)

Invoking the approval of an appropriate, legitimate or respected expert is a rhetorically powerful way of reinforcing one's account (Potter, 1996). Here, no comment by the doctor is interpreted as implicit acceptance (24M-6), while medical approval is claimed for drinking in the context of claiming no other vices (12M-10) – even if intake may be interpreted as problematic (note high AUDIT-C score for 12M-10). Overall, drinking was normalised through situating consumption within routine practices, constructing 'vices' such as drinking as common, and citing approval from authoritative medical sources.

Discussion

The analysis presented builds on previous qualitative research with older drinkers by explicating the range of (inter-linked) discursive strategies used to construct drinking as moderate and to position the self as responsible. Our participants concerns to normalise and minimise their drinking underlines the contemporary representation of drinking as (potentially) damaging when consumed in 'excessive' or dependent ways. Moderation is a term used in opposition to excess or dependency, and which evokes a sense of self-responsibility and self-control. The lack of clarity regarding what 'moderate' means in terms of quantity of alcohol consumed affords flexibility in accounting practices, hence the widespread deployment of a moderation repertoire, invoking multiple discursive strategies, regardless of amount actually consumed (see also Wilson et al, 2013). Further, by situating (moderate) drinking within mundane, beneficial practices (socialising, having dinner, watching television etc.), negative impacts are rarely mentioned – except in relation to other people (self-serving comparisons) – and health risks, or indeed direct harms, are not foregrounded. Indeed, when health was made relevant by the interviewees the focus was largely on benefits e.g. relaxing, facilitating sleep, stress-reducing.

In the context of such lay accounting, where moderation is used to frame a wide range of consumption practices, exhortations to drink responsibly which now permeate alcohol-related marketing and health-promotion campaigns may in fact reinforce current drinking levels (see Room, 2011). As other researchers have noted, health promotion efforts around alcohol could more profitably connect more closely with the language, contexts and practices referenced by drinkers to enhance relevance and impact of messaging - for example, by focusing more on more proximal problems rather than on distant risks (see Muhlack et al., 2018). In addition, developing awareness of discursive strategies could help create specific discursive intervention approaches when vague amounts are presented, or when self-serving accounts are offered. Similarly, when health or other harms are hinted at, more fine grained attention to such talk, particularly when it is naturally occurring, may serve to develop conversational strategies to open up subjects that are routinely closed down discursively. There is evidence that health professionals are often not confident in pursuing the subject of alcohol with patients (Authors, forthcoming; Moriarty et al., 2011; Rapley et al 2006), so knowledge about lay repertoires could prove useful in consultations.

Our interviewees seemed willing to talk about alcohol, hence the rich, detailed accounts which are interesting in many ways. As regards consultations with health professionals, however, it is well known that there is a reluctance to talk openly about alcohol consumption and that downgrading drinking is even more pronounced (e.g. Denvir, 2012). Further scrutiny of the discursive practices involved may be useful in various ways. Our analysis points to the value of eliciting detailed lay accounts and focusing not just on what people say but how they say it. The active, creative and sophisticated strategies presented by our interviewees suggest that alcohol is an interesting and important topic for older drinkers, and that they are invested in portraying themselves and their drinking as context-bound, moderate and respectable. These accounts also indicate that older people understand the risks associated with alcohol use, at least to the extent they recognise the importance of presenting their own use of alcohol as responsible, relative to other people. Better understanding why people go to such lengths may help reorientate efforts to have more useful conversations.

While the interviews produced rich accounts, it must be noted that these accounts have been generated in a particular (research) setting, and are therefore in part framed by the interviewer and the wider project (focused on medication, drinking and a potential pharmacy intervention). In future it would be important to consider further the interactional context in which interviewee accounts were produced i.e. incorporating interviewer contributions and dialogue with interviewees to perform a more detailed discourse analysis. This could be especially helpful in understanding how

people respond when their accounts are questioned, thereby suggesting potential communicative strategies that encourage more open conversations. This may in turn help people to engage in less risky drinking practices. While it would be interesting to consider accounts by older drinkers in other settings, particularly those free from researcher influence (e.g. conversations with friends, online discussions), it is noteworthy that other researchers have identified similar basic themes (see Muhlack et al., 2018; Kelly et al., 2018). In addition, and despite recruitment efforts, the study sample was largely white and confined to one geographical region within England – further research is required with more diverse samples in order to gauge the transferability of this analysis. Finally, it might be useful to look more closely at different age subgroups within the 'older' category since the concerns of people in their 50s pertaining to alcohol, medication and health may be different compared to people in their 80s, for example.

To sum up, thisanalysis highlights the concerted efforts interviewees made to present themselves as good citizens: displaying self-regulation, emphasising moderation and decrying excess and dependence in others. This pattern of accounting links to wider, interlinked, concepts such as healthism, responsibilisation and lifestylisation, whereby individuals are interpellated as self-monitoring subjects putatively in control of their bodies, health and wellbeing through the personal choices they make (cf Crawford, 1980; Lupton, 1995; Lucivero & Barbara, 2015), including alcohol consumption (Room, 2011). To be a good citizen is to be in control i.e. enjoying alcohol in moderation and not causing problems for self, others or society in general.

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