2020

Familial Caregivers' Perceptions of Alcohol Use Among Mature Adults Residing in Assisted Living Communities

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Walden University
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Abstract

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MSW, University of Alabama, 2008

BSSW, University of Alabama at Birmingham, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health

Walden University

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Abstract

Research suggests that alcohol abuse is among the 8 primary causes of death for mature adults, which includes individuals age 65 and older. Alcohol use is a growing, unaddressed, public health concern among this referent population. Additionally, as mature adults enter the retirement phase of their lives, many of them transition to residing in assisted living communities. The purpose of this study was to explore mature adults' alcohol use in assisted living communities and how such use, as perceived by the familial caregivers, affected the mature adults' ability to age successfully. The population under study consisted of 8 familial caregivers, all women, 18 years and over who were the child or relative of a mature adult currently living in an assisted living community in the United States. The Life Course Health Development model provided the framework for this study. This model uncovered the emotional, physical, and social experiences related to alcohol consumption, that occurred before and after the mature adult moved into the assisted living community. Data were collected via semi-structured, face-to-face, and telephone interviews with the participants, and hand-coding was used to generate themes. Findings indicated that the familial caregivers agreed that the alcohol use of the mature adults residing in the assisted living community affected their overall health and social interactions among their peers. The implications for social change include arguing for specific public health policies that would ensure that assisted living communities can appropriately handle the life transitions of mature adults, which includes monitoring alcohol consumption patterns within the assisted living community, which could potentially improve the lives and the life expectancy of their mature adult residents.

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Dedication

This dissertation is dedicated to two of the largest owners of my heart, my mother, Gwendolyn Cade Anderson and my husband, Marlon L. Chambers. Thank you both for your unwavering encouragement, prayers, support and constant understanding of my dissertation journey. To my father, aunts, in-laws, extended family and my closest friends, thank you for continuing to be encouraging and supportive and very understanding of the many missed activities because I needed to write. This completed dissertation is for all of us. I may not have taken the easy road, but I made it the finish line!

Acknowledgements

This space does not suffice for me to be able to provide acknowledgement for all who have assisted, supported and encouraged me throughout this dissertation journey. I would like to acknowledge and thank Dr. Jennifer Oliphant, Dr. Diana Stark-Ekman and Dr. Magdalene Aagard, you all are the best chairperson and committee members ever! You all were major players in helping me to realize my research and writing potential and I am forever indebted to each of you. Dr. Beth Hewlett and Dr. Risa Gorelick, of Defend & Publish, LLC, from the very beginning you both were so positive, patient and encouraging. Leanne Messer and Emily Milton, thank you for showing such interest in my research and for simply being the amazing women that you are. You both are true jewels to the field of long-term care, and I am grateful for your friendship.

Finally, I would like to extend my gratitude to the participants of this study. Your willingness to share your story is one of the main reason for my done dissertation. Thank you for your openness, enlightenment and wonderfully told stories of your loved ones. Each of you in both the listed and unlisted ways contributed to my ability to make it this far in my journey, and for that, I thank you!

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Chapter 1: Introduction to the Study

Introduction

As reported by the Administration for Community Living (ACL, 2019), census estimates revealed an annual net increase from 2016 to 2017 of 1.6 million in the number of individuals age 65 and older. The ACL (2019) further reported that the population of individuals age 65 and older, increased by 34% between 2007 and 2017, and is expected to reach 94.7 million by the year 2060. In 2017, individuals who were 65 years of age had an average life expectancy of an additional 19.5 years added to their current life expectancy (ACL, 2019). With perhaps 2 decades of life ahead of them, those who are age 65—, which, for this study, will be referred to as *mature adults* (MAs)— could encounter various public health issues. According to Sacco, Bucholz, and Spitznagel (2009), as they enter a potentially long retirement, MAs could experience, for example, increased medical costs, long-term care costs, and alcohol-related problems/disorders. Alcohol-related problems in the 65 and older U. S. population warrant public health attention. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2009) conducted a national survey in 2008, which uncovered that close to 40% of adults age 65 and older drink alcohol. Other research showed that alcohol is consumed in many assisted living communities (ALCs), although the rate of consumption increases or decreases over time, based on the individual (Castle et al., 2012; Klein & Jess, 2002). According to the American Psychological Association, alcohol abuse is one of the eight primary causes of death for MAs (2016).

The phenomenon of alcohol use by MAs in ALCs could impact their ability to successfully age. Successful aging included not only how the familial caregiver viewed his or her MAs' aging process, but also the MA's longevity, life satisfaction, freedom from disability, independence, mastery and growth, and active engagement with life (Martin et al., 2015, p. 15). Although research has been conducted on the alcohol consumption habits of MAs, there has been little research on the drinking habits of MAs who reside in ALCs. Therefore, this study focused on alcohol consumption by MAs living in ALCs according to the perception of their children/relatives (in this study, referred to as "familial caregivers"). According to a study conducted by Gaugler and Kane (2007), family members often visit and provide some degree of assistance to their loved ones in ALCs. For this reason, using this population seemed appropriate.

Alcohol consumption by the MA population is a growing public health concern as this consumption hinders their ability to successfully age. Chapter 1 outlines the growing public health concern of alcohol consumption by MAs living in ALCs. One of the main areas the chapter examines is whether consuming alcohol affects MAs' ability to successfully age in an ALC setting. This introductory chapter discusses the background of the study, problem statement, purpose, research questions, nature of the study, theoretical foundation, definitions, limitations, delimitations, assumptions, and the significance of the study.

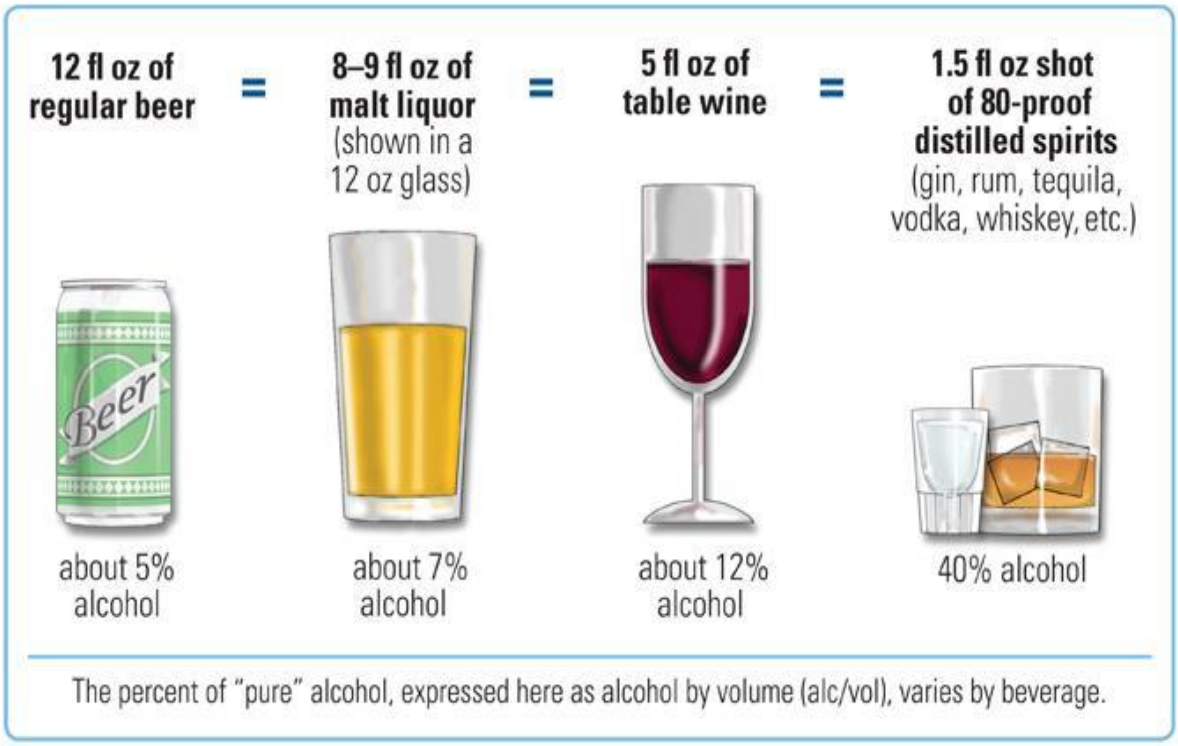
Problem Statement

As discussed by Burruss, Sacco, and Smith (2014), a healthy individual may experience adverse health outcomes as a result of alcohol consumption. Two of these

outcomes include cardiovascular disease and an increased risk of falls. According to Barry and Blow (2016), alcohol, consumed in moderation, is usually acceptable and does not pose what the field of public health would consider a major health issue. However, MAs, mainly those who take certain medications and who have health problems, can experience an array of complications from drinking alcohol, particularly if they drink heavily (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2016). Therefore, the NIAAA (2016) has suggested that healthy MAs who do not take medications, have no more than three drinks per day or seven drinks per week. A standard alcohol-based drink according to the NIAAA (2016) contains around 14 grams of pure alcohol. A six-pack of beer (12 ounces per can or bottle) equals six standard drinks, as does a 750-milliliter bottle of wine dispensed at 5 ounces per glass (NIAAA, 2016). The U.S. Department of Health and Human Services (HHS), published a pamphlet, *Rethinking drinking: Alcohol and your health*, which includes a graphic that shows four types of standard drinks (see Figure 1).

Figure 1

Examples of one standard Drink



Note. Examples of one standard drink. From *Rethinking drinking*, by U.S. Department of Health and Human Services, retrieved from https://pubs.niaaa.nih.gov/publications/RethinkingDrinking/Rethinking_Drinking.pdf Copyright 2016 by NIH.

Current research shows that unhealthy alcohol use, defined above as consuming more than three drinks per day or seven drinks in a week, is a public health issue that many MAs face (Kuerbis & Sacco, 2012). Currently, there is limited research on understanding the perspectives of MAs' drinking habits from the perspective of the MAs' familial caregivers (Burruss, Sacco, & Smith, 2014). Kuerbis and Sacco (2012) found that the prevalence of MAs with alcohol use disorders is currently about 4%; however, it can range up to 22% among those who present to hospital emergency departments and who receive care on medical inpatient units. Furthermore, in a study conducted by Han,

Moore, Sherman, Keyes and Palamar (2017), it was concluded that between 2005 and 2014, in the United States, alcohol use among older adults (including the MA population), particularly women, is continually increased. While these rates may seem small the underreporting rate of heavy alcohol consumption in MAs could have impacted these percentages (Kuerbis & Sacco, 2012). Therefore, it is important to have a more complete understanding of the alcohol use trends of adults age 65 and older in order to create more appropriate public health screenings and interventions for what is a growing public health concern among this population.

A subset of the public health concern of MAs drinking alcohol, binge drinking, is an issue for this population as well. According to the Centers for Disease Control and Prevention (CDC, 2015), binge drinking is commonly associated with adolescents and young adults. In its document on binge drinking, the CDC (2015) indicated that one out of every six U.S. adults, aged 18-34 years, binge drinks at least four times each month; the average drinker consumes approximately eight alcoholic beverages per binge. However, the CDC (2015) found that binge drinking happens quite often among aging populations, including MAs. Additionally, MA binge drinkers tend to binge more often, averaging five to six times per month, while drinking eight alcoholic beverages per binge (CDC, 2015).

One reason MAs, like other populations, drink alcohol is to reduce stress. Beginning at age 65, 23% of MAs transition into ALCs for long-term care (Podgorski et al., 2010). This shift, as Podgorski et al. (2010) suggested, can be stressful and may involve some loss of homeplace, possessions, and independence. It is possible that MAs

may mask their sense and degree of loss by drinking alcohol, which can be a problem for them and their families. The field of public health has yet to adequately address the drinking habits of MAs who reside in ALCs.

Also, little is known about the ability of MAs to successfully age in their ALCs, and what, if any, affect the consumption of alcohol has on their success. Successful aging can be defined in various ways, depending on the context in which it is being presented. For this study, factors closely associated with successful aging include longevity, life satisfaction, freedom from disability, independence, mastery and growth, and active engagement with life (Martin et al., 2015, p. 15). It also included an awareness of self and surroundings, a high level of resilience, and a lower level of depression (Jeste et al., 2013). Finally, successful aging also included how the familial caregiver viewed his or her MAs' aging process. Exploring the successful aging of MAs is necessary because it can influence the development of evidence-based policies in ALCs that provide care for MAs who use alcohol. Additionally, it uncovers a problem that is often not discussed, which is the underreporting of drinking among MAs.

Purpose of the Study

The goal of this phenomenological study was to explore the public health issues of MAs who live in ALCs and consume alcohol on their ability to successfully age in their ALC based on the perspectives of their familial caregivers. Familial caregivers, for the purpose of this study, refers to any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, an older person or an adult who may not necessarily have a chronic or disabling condition.

These individuals may be primary or secondary caregivers and live separately from the person receiving care. The population under study consisted of adult women, ages 18 and over, who were the child or relative of a MA who resided in an ALC in the United States. The familial caregiver participants were all related to the MAs who consumed alcohol. These relationships were all genetic, with the exclusion of one participant who was related by marriage. Each familial caregiver had an awareness of the MAs' consumption of alcohol in the ALC setting. Previous studies addressed unhealthy drinking patterns in "young-old adults," a term coined by McGinnis and Zelinsky (2003), which referred to individuals who were "67-75 years of age," who could encounter various public health issues (499). Other studies on this population focused on the factors associated with reductions in alcohol use that occur with advancing age (see Barry & Blow, 2016; Kuerbis & Sacco, 2012; Klein & Jess, 2002). Currently, there are no studies that examine what familial caregivers report as influencers of change on their MA's drinking habits, specifically among those who live in ALCs.

This research provides insight based on the perspectives of MAs' familial caregivers as research participants. Gaugler and Ewen (2005) argued that there has been minimal exploration into the social ramifications that are faced by older adults (including the MA population) and their family members as they transition into ALCs. They concluded that there was a high degree of family involvement in the ALC, and that the residents received frequent phone calls (e.g., once weekly or more) as well as in-person visits from their families (Gaugler & Ewen, 2005). Further, Gaugler and Ewen (2005) highlighted that ALC residents reported that their families were highly supportive from a

socioemotional standpoint (see Keating et al. 2001). Thus, it seemed reasonable to use this population of individuals to further delve into the public health issues surrounding MAs' consumption of alcohol in the ALC setting.

Research Questions

This research study addressed the following questions:

RQ1: To what extent do daily experiences in assisted living communities result in alcohol use by MAs, as perceived by their familial caregiver?

RQ2: Do loneliness or social isolation, as perceived by the familial caregiver, affect the ability of the MAs to age successfully in place in the assisted living community?

RQ3: What emotional, physical and social challenges do familial caregivers perceive their MAs parent/relative face by consuming alcohol in the assisted living community?

RQ4: How do the familial caregivers of MAs describe the alcohol consumption of their MA parent/relative in the assisted living community?

The phenomenological approach was selected to examine, based on the perspectives of the familial caregivers, the public health issues faced by MAs who reside in ALCs and consume alcohol. Participants in this study were relatives of a MAs who admitted to drinking alcohol. This study provided an opportunity for these relatives to share their perspectives via face-to-face or telephone interviews. The objective of the study was to explore, based on the perceptions of their familial caregivers, the public

health issues faced by MA alcohol users, and how their alcohol use affected the ability of MAs to successfully age in place.

Theoretical Foundation

The theoretical basis for this study was Halfon and Hochstein's (2002) life course health development (LCHD) model. This model was created to explain how health trajectories develop over an individual's lifetime, and how the knowledge taken from these development assisted with the creation of new policies and research, specifically in the field of public health. Four principles best characterize this model and what it can reveal: the (a) multiple contexts of health development, (b) the design and process of health development, (c) mechanisms that account for variation in the trajectories of health development, and (d) integration of multiple time frames of healthy growth (Halfon & Hochstein, 2002). For this study, I focused on principle (d), which suggests that experiences depend on when they occur in a person's life (Halfon & Hochstein, 2002). The LCHD model suggested relevant themes for understanding the risk behaviors and environmental agents that people encounter throughout their lives and how these factors affect their overall health and functionality (Yu, 2006). The effect for this study was measured based on the insight of the familial caregivers of the MAs.

Halfon and Hochstein's LCHD model (2002) explains that the way people handle their life transitions could affect their overall health development as well as their functional trajectories. Specifically, in principle d, Halfon and Hochstein suggest the use of time frames to address how an individual's health development occurred and what patterns, if any, could be identified during each critical period of his or her lifetime. The

authors determined that, in the 20th century, early childhood experiences led to chronic diseases in both individual and larger populations. These chronic diseases were specified in both their time-dependent biological and social processes (p. 453). An individual's brain either learned from its own experiences or used expected inputs from external stimuli, and, because of this, an individual could significantly reshape his or her life solely based on experiences that he or she faced. For example, an individual's ability to learn a language was considered experience-expectant, meaning that it is predetermined and encoded by their exposure to any language, whereas learning English instead of Japanese was experience-dependent, meaning that it is a result of specific learning experiences that vary across individuals and cultures (Halfon & Hochstein, 2002).

Therefore, using the LCHD framework was appropriate to determine what factors, over the MA's lifetime, resulted in a decision to begin or continue to use alcohol in the ALC. This framework identified lifelong experiences that are associated with the MAs' decision to drink, along with how drinking affected his or her ability to socialize with peers in assisted living communities and maintain a healthy quality of life while using alcohol. A more detailed explanation of this model is provided in Chapter 2.

Nature of the Study

In this study, the phenomenological approach gave insight into the perspectives expressed by the familial caregivers of MAs about their account of the phenomenon of alcohol use in an ALC. It is these experiences that gave meaning to an individual's

perception of a phenomenon and, accordingly, identified to that individual what was real in his or her life (Penner & McClement, 2008, p. 93).

Before selecting the phenomenological approach, other qualitative methods of inquiry were explored but were considered less practical for use. For example, a discourse analysis attempted to evaluate how an individual accomplishes social, personal, and political ventures through their use of language (Starks & Trinidad, 2007). This method of inquiry traced the historical evolution of language practices along with examining how individual language shapes and reflects cultural, social, and political practices (Starks & Trinidad, 2007). This method of inquiry would do little for this study. Primarily, it is language specific, and, although it could highlight how personal and group identities were formed in settings such as ALCs, it would not explain how alcohol use affected the overall public health issues faced by MAs in settings of this nature.

Another qualitative method of inquiry explored was grounded theory. This theory examined the six C's of the social process—causes, contexts, contingencies, consequences, covariances, and conditions—to best understand what patterns and relationships existed among these methods (Starks & Trinidad, 2007). This thorough approach used careful observations of individual behavioral patterns. However, this approach may not be as effective with familial caregivers of MAs, the chosen population of this study, for this reason. This research gathered all information from face-to-face and telephone interviews, including any minor behavioral observations, with the subjects. Therefore, phenomenology was most appropriate because it afforded me a chance to understand the lived experiences of the MA population according to the perspectives of

their familial caregivers. With a phenomenological approach, the meaning behind the phenomenon was clarified as opposed to merely being explained or attempting to discover a cause (Penner & McClement, 2008).This study sought to learn whether most MAs who reside in an ALC and who drink alcohol could successfully age in their ALC.

Definition of Terms

Activities of daily living (ADLs): Activities of daily living or ADLs is a term used by healthcare professionals to refer to the basic self-care tasks an individual does on a day-to-day basis. These activities are fundamental in caring for oneself and maintaining independence. An individual's ability or inability to perform ADLs is often used by health professionals as a way of measuring an individual's functional status, especially that of older adults or those with disabilities (Seniorliving.org, 2019).

Assisted living community (ALCs): A system of housing and limited care that is designed for senior citizens who need some assistance with day-to-day activities but are not sufficiently incapacitated to require care in a nursing home and that usually includes private quarters, meals, personal assistance, housekeeping aid, monitoring of medications, and nurses' visits (Merriam-Webster, 2017).

Baby boomer: A person born during a period in which there is a marked rise in a population's birthrate: a person born during a baby boom. Especially a person born in the United States following the end of World War II (usually considered to be in the years from 1946 to 1964) (Merriam-Webster, 2019).

Cumulative mechanisms: Focuses on exposure and how exposure to one problem can lead to another problem (Halfon & Hochstein, 2002, p. 449).

Familial caregiver: Any relative, partner, friend or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, an older person or an adult with a chronic or disabling condition. These individuals may be primary or secondary caregivers and live with, or separately from, the person receiving care (Family Caregiver Alliance, 2014).

Functional trajectories: Include an individual's cognition, mood, physical activity, growth, and fertility throughout their life course (Halfon & Hochstein, 2002, p. 438).

Late-middle age: Individuals between the ages of 55-69 (Janssen et al., 2005, p. 776).

Successful aging: Includes how an individual view his/her aging process. Factors closely associated with successful aging include longevity, life satisfaction, freedom from disability, independence, mastery and growth, and active engagement with life (Martin et al., 2015, p. 15).

Young-old adults: Individuals between the ages 65-75 years (McGinnis & Zelinski, 2003, p. 499).

Assumptions

Three assumptions were made for this study. The first assumption was that all participants would be honest in their responses and secondly that the questions that were developed would understand the phenomenon under study. The third assumption was that the participants would remain engaged and not multitask throughout their interviews so that an acceptable amount of information about the phenomenon under study could be

gathered. As some interview were not conducted face to face, this was a concern. It was expected that the participants' level of comfort would allow for all comments, including both positive and negative comments, to be shared where necessary to answer the proposed study questions.

Scope and Delimitations

Simon (2011) explained that the researcher controls delimitations. Simon (2011) suggested that delimiting characteristics limited the scope of ones' study, as well as defined its boundaries. Alcohol use had the potential to both physically and mentally affect all consumers, regardless of age, current physical or mental health, or current living arrangement. For this reason and to best assess the population under study, the scope of this study was limited to the perceptions of familial caregivers of MAs, currently residing in ALCs, in the United States. The familial caregivers of MAs were not broken into subsections by the city, state and/or ALC in which their MAs resides.

Limitations

This study filled a gap in the literature which highlights that the field of public health has yet to adequately address the drinking habits of MAs who reside in ALCs. This study was limited to the familial caregivers of MAs who used alcohol in ALCs in the United States. According to Roberts, Ogunwole, Blakeslee, and Rabe (2018), 9% of the U.S. population in 2015 were aged 65 and older. Of this population, Roberts et al. estimated further that 58% were between the ages of 65-74 and 29% between the ages 75-84 (2018). The authors predicted that by 2050, the number of individuals aged 65 and older would increase to 17% of the total population (Roberts, et al., 2018). As earlier

noted, beginning at age 65, 23% of MAs transition into ALCs for long-term care which can be stressful for the transitioning MA, and possibly result in an increase in their drinking habits in or to mask their real feelings (Podgorski et al., 2010).

Significance of the Study

This study was expected to add to the current body of literature on the perceptions about alcohol use by those 65 and older (see Zanjani et al., 2013; Sacco, Bucholz, & Harrington, 2014; Blazer & Wu, 2009a; Castle et al., 2012; and Klein & Jess, 2002). Specifically, this study sought to fill a gap in the literature on the drinking habits of MAs residing in ALCs, and how their alcohol consumption affected their ability to successfully age in their ALC. This research could help address the growing public health needs of MAs about the amount of alcohol they consume while residing in ALCs by implementing public health policies to address alcohol consumption in ALCs.

Findings from this study could also be used to validate the role alcohol consumption plays in the ability of MAs to successfully age in an ALC. By placing familial caregivers of MAs at the heart of this study, a critical voice—previously overlooked—has been included. Furthermore, this study addressed policy changes that should be put into place by ALCs to address MAs alcohol-related issues.

Significance to Positive Social Change

Findings from this study have the potential to create positive social change for an underassessed public health problem in the aging population. The results may (a) improve public health awareness of the MAs' ability to successfully age when they transition into and live in ALCs and (b) contribute to current information about the

drinking habits of MAs as perceived by their familial caregivers. Data from the participants were used to identify themes that could help in evidence-based policy development on a local and national level for this public health problem. The knowledge gained from this study could further be used to direct the public health education of medical providers and primary caregivers for this population on a local and national level.

Summary and Transition

As of 2017, individuals who are 65 years of age were estimated to have an additional 19.5 years of average life expectancy (). Many of these individuals have retired and have chosen to spend their remaining years in communities like an ALC, for a variety of reasons, which may include social relationships or the need for assistance with day-to-day activities. Alcohol consumption can be exacerbated for different reasons, which include loneliness and social motivation. The results from this study have the potential to provide ALC administrators and staff, policymakers, MAs, familial caregivers of MAs, and medical professionals with the information necessary to support the argument that public health policies should be created. These policies should ensure that MAs in ALCs can handle their life transitions appropriately as to prevent an adverse effect on their overall health development and ability to successfully age. Public health policies related to recommended amounts of alcohol consumption at ALCs could improve the lives and the life expectancy of MAs who reside in these facilities.

Chapter 2 discusses the literature search strategy, the theoretical framework, and the public health and social science research on alcohol abuse and binge drinking among

the population of MAs. Chapter 3 outlines the study's approach to understanding how MAs in ALCs use alcohol, and what effects, if any, such drinking has on their ability to successfully age. Also discussed are the participant selection process, the role of the researcher, the ethical measures taken to protect the study's participants, the data collection plan and the analysis procedures. Chapter 4 provides a thorough analysis of the study's results. Chapter 5 concludes with a discussion of the study's findings and the implications for positive social change through public health alcohol policy recommendations for MAs who reside in ALCs.

Chapter 2: Literature Review

Introduction

Alcohol consumption in the United States causes alcohol use disorders, alcohol-related deaths, economic burdens, and other associated consequences (e.g. medical issues, underage drinking, etc.). As such, a wealth of research on alcohol consumption and abuse has been published. However, after a careful review of the literature, only a few peer-reviewed studies focused on alcohol use in adult men and women age 65 and older (referred to as MAs in this study), and none addressed familial caregiver concerns about MAs' alcohol use in ALCs (see Zanjani et al., 2013; Sacco, Bucholz, & Harrington, 2014; Blazer & Wu, 2009a). As MAs continued to grow as a segment of the population, more public health issues will surface for them (Zanjani et al., 2013); some of the public health issues faced by MAs are directly related to their use of alcohol. Therefore, this study focused on alcohol use by MAs in ALCs.

Research showed that alcohol consumption occurs in many ALCs, although the rate of consumption has changed over time (Castle et al., 2012; and Klein & Jess, 2002). In fact, researchers have addressed some of the factors associated with a reduction in alcohol use that occurred with advancing age. However, few studies addressed what MAs and their familial caregivers reported as influencers of change about their alcohol consumption habits (Borok et al., 2013; Sacco et al., 2015; Kuerbis & Sacco, 2012; Kuerbis et al., 2014). Thus, there was a gap in the literature regarding the drinking habits of MAs residing in ALCs based on the perspectives of their familial caregivers. As such, this study examined the public health issues related to MAs residing in ALCs and their

ability to age successfully (based on the perspectives of their familial caregivers). This chapter discusses (a) the literature search strategy, (b) theoretical framework, (c) a general overview of alcohol abuse and binge drinking among MAs and (d) the public health and social science literature research on alcohol abuse and binge drinking among the population of MAs.

Search Criteria

Information was retrieved from the following sources: peer-reviewed journals, data from public health databases within the Centers for Disease Control and Prevention, the National Institute on Alcohol Abuse and Alcoholism, books, and publications that target senior populations (AARP and the Senior Directory). The following databases were used for the period 2000-2019: MEDLINE with Full Text, CINAHL Plus with Full Text, ProQuest Nursing and Allied Health Source, PubMed, ScienceDirect, and PsycINFO. The following keywords and phrases were used for these searches : *assisted living, alcohol abuse and binge drinking, public health issues and aging populations, life course health development model and aging populations, race and/or ethnicity issues in older adults and/or aging populations, caregivers of older adults and/or aging populations,* and *family issues with aging populations.*.

Theoretical Framework

The life course health development framework (LCHD) included themes for understanding the risk behaviors and environmental agents that were encountered throughout people's lives and how these factors affected their overall health and functionality (Yu, 2006). The LCHD framework served as a foundation for understanding

the relationship between assisted living dwelling MAs' drinking habits and their overall health and well-being based on the perceptions of their familial caregivers. The LCHD framework was developed in the 1960s to provide explanations as to how health trajectories will develop over an individual's lifetime, and how the knowledge taken from these explanations can assist with the development of new policies and research, specifically in the field of public health (Halfon & Hochstein, 2002). When contrasted against other theories that study human development, the LCHD framework is a conceptual tool which focuses on characteristics related to length of exposure, duration dependence, trajectories, transitions and turning points (Seabrook & Avison, 2012). Additionally, this framework considered healthy aging as a prominent function possessed by humans that developed over time, in response to various genetic, biological, behavioral, social, and economic factors that were constantly changing (Davis et al., 2016).

According to Halfon and Hochstein (2002), four principles characterized the LCHD framework; these include the "(a) multiple contexts of health development, (b) design and process of health development, (c) mechanisms that account for variation in the trajectories of health development, and (d) integration of multiple time frames of health development" (p. 437). Halfon and Conway (2013) explained via evidence that many of the chronic health conditions that affect older adults originated in their earlier exposures, experiences, and behaviors. For example, Gwen resided in an ALC. Based on this framework, her health development possibly stemmed from her family environment as a young child, the neighborhoods in which she lived, and individual behaviors as she

aged. An extensive literature review indicated that this model was most used in areas of maternal and child health (MCH) (see Halfon et al., 2014). Although there was no literature identified in which the LCHD framework explicitly focused on alcohol issues by MAs in ALCs, the principles associated with this framework are a significant base in which to set up a study on the use of alcohol by MAs in ALCs. Accordingly, this study was an opportunity to expand on the LCHD framework outside of the area of MCH.

According to principle (a) of the LCHD framework, an individual's health outcomes could be affected by more than one factor (Halfon & Hochstein, 2002). Additionally, a correlation may exist between a single environmental element and specific health outcomes (Halfon & Hochstein, 2002). In studies of elderly populations, early life experiences and genetics played a role in "modifying functional trajectories such as critical problem-solving" (Halfon & Hochstein, 2002, p. 441). Therefore, an individual's life path was related not only to the contexts by which s/he may have been affected (e.g., social, physical, and environmental) but also to his/her familial or individual responses from genetic adaptation (Halfon & Hochstein, 2002). In this study, therefore, familial caregivers were interviewed to best understand the effect alcohol use has on the ability of their MAs to successfully age in an ALC.

In principle (b) of the LCHD framework, Halfon and Hochstein (2002) clarified the relationship that existed between health and social contexts. Halfon and Hochstein found that human physiological systems were examined to determine a person's health development, and each system, with its unique attributes, played a role in programming an individual's health development. Since these systems were not fully functional at

birth, they can be programmed based on an individual's responses to different short- and long-term functional changes that the individual faced throughout his or her lifetime, such as childhood asthma. As explained by Halfon et al. (2014), an individual reached optimal life course health development when the approach to their overall health was inclusive of "the whole child, whole family, and whole community" (p. 360). Events in people's early life influenced their lung development, as well as their immune system's response to fight off infection and other toxins that challenge people's airways (Halfon & Hochstein, 2002). These early asthma influencers included both pre- and postnatal exposure and response patterns, and, as suggested by Halfon and Hochstein (2002), programming of these response patterns early on in a person's life appeared to significantly influence the trajectory of the person's adult lung functioning (p. 448). Adults exposed to early asthma influencers may face an earlier decline in their overall health function, as well as preventable, premature disability from lung conditions such as chronic obstructive pulmonary disorder (COPD).

In principle (c), Halfon and Hochstein (2002) defined an individual's health development as an interaction that existed between his or her cumulative and programming mechanisms (p. 449). These mechanisms were gene-controlled and could also be affected by past responses and experiences, including one's socioeconomic status (SES). As explained by Seabrook and Avison (2012), an individual's SES was a reliable predictor of health disparities, with those from lower SES predominately being the one's to experience poorer health than those from higher SES. An individual's early life social disadvantages can cumulate throughout the life course, resulting in an increase in health

disparities for those from lower SES (Seabrook & Avison, 2012). Programming mechanisms, on the other hand, primarily focused on early life exposure, and how exposure, especially during these periods of development, affected long-term development (Halfon & Hochstein, 2002). An example of this mechanism would be birth weight and an infant's weight gain and growth in its first year of life, which was associated with cardiovascular disease and other chronic illness later in life (Halfon & Hochstein, 2002).

In principle (d), Halfon and Hochstein (2002) used time frames to address how an individual's health development occurred and what patterns, if any, can be identified during each critical period of his/her lifetime. Halfon and Hochstein (2002) determined that, in the 20th century, early childhood experiences led to chronic diseases in both the individual and larger population. These chronic diseases were noted by Halfon and Hochstein (2002) as specified in both their time-dependent biological and social processes (p. 453). There was evidence that an independent predictive effect existed for adult disease and disability as it related to prenatal and early childhood factors, precisely, an infant's birth weight, weight gain during infancy, and growth rate and height (Halfon and Hochstein, 2002, p. 453). Other exposures included maternal socioeconomic status and attachment to the child by the parent, the child's educational attainment, and the child's parents' divorce rate, as well as the parents' smoking habits. Some of these exposures exerted their influence during small developmental time periods, whereas others presented for several years (Halfon and Hochstein, 2002). An individual's brain either learned from its own experiences or used expected inputs from external stimuli,

and, because of this, an individual could significantly reshape his/her life simply based on experiences that s/he faced. For example, an individual's ability to learn a language was considered experience-expectant, encoded by their exposure to any language, whereas learning English instead of Japanese was experience-dependent (Halfon & Hochstein, 2002).

Halfon and Hochstein (2002) explained that the way people handle their life transitions could affect their overall health development, as well as their functional trajectories. An individual who left the workforce after spending 50 years of his/her life working five days per week for 160 hours per month was now home, often alone, daily, and many of his/her friends were either still working or are deceased. S/he turned to alcohol to cope with his/her loneliness and began to drink alcohol daily; before much time has passed, this individual consumed a few alcoholic drinks per day. Based on the turning point that occurred in this person's life, his/her health development and functional trajectories are altered, and s/he may now become affected by a chronic condition that s/he may not have otherwise faced if his/her lifestyle had not changed. Therefore, using the LCHD framework can determine what factors, over an individual's lifetime, have resulted in their decision to begin or continue to use alcohol in an assisted living setting, based on the perception of their familial caregivers. This framework identifies lifelong experiences that are associated with their decision to drink, along with how their drinking affects their ability to socialize with their peers in assisted living and maintain a health quality of life while using alcohol.

Mature Adults (MAs), Alcohol Abuse, and Binge Drinking

Mature Adults (MAs)

According to Kuerbis and Sacco (2012), alcohol was one of the most common substances abused by individuals 65 years of age or older. One of the risk factors that contributed to unhealthy alcohol use among this age group was late life retirement (Wang & Shultz, 2010). Wang and Shultz (2010) expressed that retirement was an adjustment process in which the older adult must adjust to the changes that he or she faced by deciding to no longer work and achieving psychological comfort within his or her newfound retired life (p. 177). The HHS (2016) reported that 46.2 million individuals living in the United States are 65 years of age or older. Of that number, according to the Social Security Administration (2017), 42 million were currently retired.

In 2017, however, individuals who were 65 years of age, according to the ACL, had an additional 19.5 years added to their average life expectancy (2019). These additional years were most closely associated with reduced deaths rates across various age ranges from children to young adults (ACL, 2019). With almost twenty years of life expectancy ahead of them, MAs had the potential of encountering public health issues, including increased medical costs, alcohol-related problems/disorders, and long-term care costs, as they entered a potentially long retirement age (Sacco, Bucholz, & Spitznagel, 2009). Sacco et al. (2009) exacerbated these concerns in a study, in which it was concluded that older adults who were current drinkers often exceeded the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) recommended drinking guidelines of no more than three drinks per day or seven drinks per week. Therefore, the

study found that alcohol usage played a role in the larger pattern of health risks, including major depression and alcohol dependency (Sacco et al., 2009).

Studies by Levy, Slade, Kunkel, and Kasl (2002) and Levy, Zonderman, Slade, and Ferruci (2002) determined that individuals who negatively thought about aging in late-middle age are both less healthy and less satisfied with their overall lives several years later than those who had a positive outlook on aging. Adams-Price, Turner, and Warren (2015) compared the concerns of early wave baby boomers to young-old adults using data from a Mississippi statewide older adult needs assessment survey via a random sample landline telephone survey. Early wave baby boomers were described as individuals from 55 to 64 years old, and young-old adults are from age 65 to 75 (Adams-Price et al., 2015). The young-old adult population identified in this study exhibited similarities in their habits to the MAs population, the focus of this research study.

The truth uncovered by Adams-Price et al. (2015) was that baby boomers and young-old adults could maintain their independence in an ALC. Accordingly, Adams-Price et al. (2015) determined that baby boomers were more prepared for their future aging process than young-old adults who had a more relaxed attitude towards their future aging issues. Adams-Price et al. (2015) expressed, however, that this study posed several limitations that could have affected their outcomes. They claimed the most prominent limitation was that the needs assessment instrument was designed to identify generic services provided by the state rather than for both populations' late-life health concerns. This assessment focused primarily on the financial, health, and employment matters of young-old adults, and not the social needs such as their fears for their future (i.e., will

they have someone to provide care for them later in life) (Adams-Price et al., 2015). Additionally, study respondents were limited to those individuals who had landline phone service and excluded those whose primary method of communication was via a mobile phone. It is highly likely that the study population was not representative as many individuals were moving away from landline phone service and instead have mobile phones. Finally, the study primarily focused on married, white females in Mississippi whose highest level of education was a high school diploma that omitted many other populations (e.g., males, unmarried, those with education, those residing in other states, etc.).

Adams-Price et al. (2015) omitted other concerns, such as societal aging, which posed local and global challenges. For example, Adams-Price et al. (2013) were unconcerned about an increase in disabilities due to age-related chronic diseases and an inability to provide the resources necessary to ensure that both populations can "age in place" (National Institute on Aging, 2007). More importantly, public health policy development must address the challenges such as rising health care costs and an increase in disabilities due to age-related chronic diseases that were faced by an aging society (Adams-Price et al., 2013; National Institute on Aging, 2007). Finally, more research should focus on solutions to the anxieties experienced by those who are approaching the 65 and older age population rather than stereotypical fears related to aging.

To assess these concerns, Steptoe, Shankar, Demakakos, and Wardle (2013) conducted a study of men and women aged 52 and older in 2004-2005, using the English Longitudinal Study of Ageing (ELSA), and tracked participant mortality through 2012.

Previous research, such as the study conducted by Luo, Hawkey, Waite, and Cacioppo (2012), yielded mixed results as it related to the whether a relationship existed between social isolation, loneliness, and all-cause mortality. In fact, there are numerous studies that specifically address the association between increased levels of social support and an improved quality of life (Gallicchio, Hoffman, & Helzlsouer, 2007; House, Landis, & Umberson, 1988; Seeman, 2000), however, there were fewer studies that address loneliness and social isolation as two independent variables, which may or not affect one's health. Steptoe et al. (2013) defined social isolation as not having contact with family and friends and not participating in civic organizations. The researchers did not identify any gender differences in social isolation, but it determined that isolated individuals were more commonly single, poor, and had no more than a high school education (Steptoe et al., 2013).

The authors argued that those who tended to isolate themselves were plagued by limiting, longstanding illnesses, such as arthritis, depressive symptoms, and chronic lung disease (Steptoe et al., 2013). Steptoe et al., however, found loneliness most commonly in unmarried, poor women ages 60-69 who had completed high school, but did not attend college (2013). These individuals were also noted to have a broader range of health conditions such as a history of strokes, clinical depression, and coronary heart disease (Steptoe et al., 2013). Steptoe et al., (2013) conducted a long-term longitudinal study over an eight-year timeframe. Therefore, it was not uncommon that a percentage of the participants died as their ages ranged from 52 years to 80 years and older (Steptoe et al., 2013). Furthermore, the authors explained that there were a few other significant

predictors of mortality during this study; they found those who were poor, older males with limited longstanding illnesses, such as cancer or chronic heart disease at the study's baseline, have higher mortality rates (Steptoe et al., 2013).

The results of the study indicated that experiencing loneliness did not explain the association between social isolation and death (Steptoe et al., 2013). The authors' findings conclusively determined that social isolation had a direct causal relationship with higher rates of mortality in older men and women, but this rate was independent of the variable of loneliness (Steptoe et al., 2013).These findings, along with studies such as Nicholson (2012), showed that not only is social isolation a significant health problem for older adults, but there were also very few needs assessment conducted among this population by public health professionals to ensure, from a holistic standpoint, the needs of this population were being met. What was not addressed in the literature, however, were interventions that have been put in place to reduce the likelihood of social isolation and loneliness among those who are MAs. These efforts provided significant benefits to this population, as it would potentially extend their lives if they were engaged in a community setting, such as an ALC, where they can participate in monitored, structured activities.

Race and Ethnicity Issues in Aging Populations

In 2014, the HHS (2016) identified that racial or ethnic minority populations in the United States made up 22% of all persons 65 years of age and older. Although life expectancies are increasing across the MAs population, certain disparities exist among racial groups that may result in shorter lifespans for some. Haas, Krueger, and Rohlfsen

(2012) studied this notion along of disparities in later life physical performance over an individual's life course. The authors discussed the significant number of racial and ethnic differences that MAs in the United States face including shorter life expectancies (in Black populations as compared to White) and increased levels of disability in both Black and Hispanic populations (Haas et al., 2012). In alignment with this study, Olshansky et al. also suggested that those men and women across all racial groups who have less than twelve years of education had life expectancies that mirrored the life expectancies of all adults in the 1950s and 1960s, which is significantly lower than current life expectancies (2012).

Haas et al. attempted to determine the role an individual's health and socioeconomic status over his/her life course played while examining racial and ethnic differences, along with the nativity differences related to each racial class' ability to physically perform (2012). The authors described physical performance in this study as an individual's grip strength, gait speed, and peak expiratory flow. The authors explained that an individual's differences in health based on his/her race/ethnicity and nativity resulted in an inability to access social opportunities, social institutions, and resources that promote health (2012). Data for this study, derived from the Health and Retirement Study, which is a population-based, representative sample of American adults age 69 and older living either in the United States or abroad (2012).

Using the LCHD, Haas et al. considered both the individual's childhood and adult health along with demographic and socioeconomic factors while determining his/her physical performance (2012). This study further considered previous studies that have

been conducted in which it was discovered that an individual's race, ethnicity, nativity, and socioeconomic status in early life determined their physical performance in later life (Haas et al., 2012). In one of those studies, Seeman et al. (1994) found that Blacks, when compared to their White counterparts, had lower scores on a physical performance index, and the volatility in their physical performance over time was higher. In another study, Markides et al. (2001) expressed that disability and mortality among Hispanics are most prominent with lower measurements on body performance and grip strength.

Haas et al. concluded that there were significant differences in race, ethnic, and nativity physical performances amongst the sampled populations (2012). American born Blacks and Hispanics were noted to have slower gait speeds, worsening lung functions (Blacks), and worsening grip strength (Hispanics) when compared to American-born White populations (Haas et al., 2012). Foreign-born Blacks and Hispanics had even worse outcomes than those American born races, as foreign-born Hispanics have worse grip strength and gait speed (Haas et al., 2012). The authors found that both parental education and childhood health affected the lung functioning of the participants (2012). Haas et al. further suggested that unskilled laborers with manual occupations who were poorer, less educated, and had limited sources of income, reported worse lung functions than their counterparts with higher socioeconomic statuses (2012). The researchers noted that higher income and wealth equated to higher grip strength in both races other than Hispanics. Although most of the race/ethnic and nativity disparities among the races reversed or became less likely per the results of this study, American born Blacks continued to have worse physical performance scores in all areas when compared to

American born Whites, even after the researchers adjusted for both childhood and adult health and socioeconomic statuses (Haas et al., 2012).

This study, like others completed before it (see Seeman et al.,1994) and Markides et al. (2001) also determined that childhood and adult socioeconomic statuses play a significant role in the physical performance of race, ethnic, and nativity groups of individuals (Haas et al., 2012). Therefore, when most people were affected by physical performance conditions, compounded by chronic medical conditions, it was likely these factors would lead to unhealthy alcohol consumption and ability to independently reside on their own. Further research should address health disparities in later life as it relates to the physical functioning of older adults, including MAs.

Alcohol Abuse

In a 2008 national survey, the NIAAA discovered that close to 40% of adults age 65 and older drink alcohol (NIAAA, 2016). The American Psychological Association (2016) expressed that alcohol abuse is one of the eight primary causes of death in older Americans, which, for this dissertation are described as individuals aged 65 and older. The CDC (2016) discussed that excessive drinking could be harmful to one's health. Excessive drinking in older adults can lead to malnutrition, cirrhosis of the liver, and an overall decline in their cognitive functioning (American Psychological Association, 2016). Excessive alcohol use, defined as consuming more than three drinks per day or seven drinks in a week (NIAAA, 2016). The NIAAA stated, "In the United States, one 'standard' drink contains roughly 14 grams of pure alcohol"

(https://www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/what-standard-drink). The NIAAA, furthermore, defined a "standard" drink as the following:

- 12 ounces of regular beer, which is usually about 5% alcohol
- 5 ounces of wine, which is typically about 12% alcohol
- 1.5 ounces of distilled spirits, which is about 40% alcohol

(NIAAA, 2016).

Many people, however, have heavy hands when they pour themselves a drink, and, therefore, consume more than the "standard" drink. To help facilitate an accurate pour, the HHS published a pamphlet, *Rethinking drinking: Alcohol and Your Health*, which includes a graphic that shows four types of standard drinks (see Figure 1).

Within the field of public health, alcohol, consumed in moderation among healthy individuals, was usually acceptable and does not pose a health issue (Burruss, Sacco, & Smith, 2014). However, when people drink more than moderately, problems can arise. In the United States, between the years of 2006-2010, excessive alcohol use resulted in approximately 88,000 deaths among all age groups, and it was the primary responsible factor for 1 in 10 deaths among those working-age adults ages 20-64 (CDC, 2016). In 2010, excessive alcohol consumption cost the economy an estimated $249 billion, which equates to more than $2.00 per drink (CDC, 2016). This cost was primarily attributed to an increase in the number of alcohol-related deaths, as well as an increase in the cost of medical care related to alcohol use (Sacks et al., 2015).

Excessive alcohol consumption has such a significant economic impact primarily because of the long-term physical, emotional, and mental health effects that it has on its

users (CDC, 2016). Furthermore, 40% of adults over the age of 55 are believed to be at risk for alcohol abuse problems, but they do not self-identify or inquire about services for alcohol abuse and are less likely to be identified by their physician as someone who abuses alcohol (American Psychological Association , 2016). The American Psychological Association recognized that this age group is at risk because of several variables that include, but are not limited to, medication mismanagement, a significant number of untreated chronic conditions, poor diets, inactivity, and undocumented mental illnesses (2016).

Sacco et al. (2015) conducted a pilot study in which they sought to describe the patterns of alcohol consumption among residents of a continuing care retirement community (CCRC). The appeal of CCRCs allowed older adults to age in place. Levels of CCRC care ranged from independent living to assisted living, to specialty care assisted living, and nursing home services, which mean that residents could stay at one facility and transition accordingly as their health care needs changed (Sacco et al., 2015). Previous research, such as Castle, Wagner, Ferguson-Rome, Smith, and Handler's (2011) study on nurse aides who work in ALCs, focused on ALCs solely, therefore, omitting retirement communities like CCRCs. CCRCs are unique as they provided MAs with a single source for all their long-term care needs.

The authors explored the reasons that older adults, including MAs, drank and whether this led to a negative or positive affective state (Sacco et al. 2015). To conduct this study, Sacco et al. (2015) used phone-based daily diaries with individuals who were 60years of age and older. Participants were asked about their daily alcohol consumption,

what motivated them to drink, and any positive or negative effects their drinking had on them and those around them. The authors chose CCRCs primarily because there has been limited research that has focused explicitly on alcohol use in settings of this nature. The researchers agreed that the use of alcohol in CCRCs should be further investigated to understand better whether there are patterns or motives related to alcohol abuse in these settings; if they determined alcohol abuse in CCRCs, their goal was to design and develop interventions specifically for these environments (Sacco et al., 2015).

The study conducted by Sacco et al. (2015) found that most of the participants drank primarily when they were home alone, and, although hazardous, the researchers considered problem alcohol use among participants to be minimal. Many of the participants expressed that although they would not mind drinking socially outside of their homes, they preferred to drink alone (Sacco et al., 2015). The authors concluded that CCRC residents are most often socially motivated to drink amongst their peers, and this social motivation is stronger than their abilities to cope with painful life experiences and other forms of psychological distress (Sacco et al., 2015). Furthermore, very few of the respondents endorsed specific alcohol-related problems as it relates to their drinking habits (Sacco et al., 2015). These findings agreed with studies conducted by Blazer and Wu (2009b), and Grant et al. (2004) which determined that there was a lower prevalence of problem drinking among adults 65 and older, but a higher incidence of at-risk drinking due to the guidelines that have been set for consumption levels (Barnes et al., 2010; and Blazer & Wu, 2009a).

As it related to public health, Sacco et al. (2015) did not analyze several factors. First, the extent to which the participants' drinking can be considered hazardous based on comorbidities, including medication mismanagement and other age-related conditions, along with the desire for socialization among the participants was not evaluated. These omissions were important, as the findings of this study were limited to the general population of older adults, including MAs, selected from only one CCRC, so the data sample is too small to generalize. Also, data was only collected once per day during the study and the participants were asked to self-report on their previous day of drinking. As a result, the authors did not explore the impact of the participant's ability to discuss their momentary effect or possible lapses in honesty. Furthermore, future research should focus on the relationship between drinking and the living environment of the MAs, while identifying those variables associated with unhealthy drinking among this population.

This literature review has uncovered that more research is necessary to identify the factors associated with MAs' alcohol use and unhealthy drinking habits. Very few of the studies conducted have focused solely on the MAs population's drinking habits (Zanjani et al., 2013; Blazer & Wu, 2009; Sacco et al., 2014). The similarities in Zanjani et al., (2013), Blazer & Wu (2009), and Sacco et al., (2014) studies were that gender effected alcohol consumption amounts among this population, and higher amounts of alcohol were most often consumed by those individuals with higher levels of both education and income. Another similarity of Blazer and Wu (2009) and Sacco et al. (2014) was that there was a clear association between binge drinking and being separated, divorced, or widowed.

However, Zanjani et al. (2013), Blazer & Wu (2009), and Sacco et al., (2014) studies disagreed on the notions that stressful events or cognitive declines caused an increase in alcohol consumption, whether tobacco and illicit drug use is indicative of binge-drinking, and whether life events caused a change in an individual's lifetime drinking habits. For example, Sacco et al. (2014) suggested that an individual's drinking problem possibly added stress to their lives as opposed to there being a direct causal relationship between perceived stresses which led to an increase in MAs' drinking. Zanjani et al. (2013), on the other hand, concluded that there was a healthy relationship between individuals' alcohol consumption amounts and how their cognitive abilities were affected. Finally, Blazer and Wu (2009) argued that binge drinking had no apparent association with serious psychological distress amongst its users.

While there were a handful of studies that examined alcohol abuse in MAs populations as seen in the studies by Blazer and Wu (2009), Zanjani et al., (2013), and Sacco et al. (2014), there has been little mention of any assessments conducted from a public health standpoint in health problems that arose when MAs drink too much alcohol. Additionally, no studies at this time identified any public health screenings or interventions that were available aimed explicitly at MAs who may be abusing alcohol. Studies indicated that most MAs used alcohol primarily based on their desire to socialize with their peers (Sacco et al., 2015). The problem occurred when the MAs were unable to recognize that their consumption of alcohol became a problem. Since most MAs took some prescription medication (and often take multiple prescription medications), they may not have been aware of the hazards that occur when these prescriptions were mixed

with alcohol. Additionally, according to Zanjani et al. (2012), adults were recommended to reduce alcohol consumption as they age. This recommendation stemmed from a decrease in endogenous water levels in which to dilute alcohol, leading to a higher blood alcohol concentration in older adults compared to those younger than 65 who consumed the same amount of alcohol (Dufour, Archer, & Gordis, 1992).

For both men and women, it had been suggested that individuals aged 65 and older should, on average, consume no more than one drink a day (National Institute on Aging, 2012; National Institute on Alcohol Abuse and Alcoholism, 2010). Also, compared to younger adults, MAs can unknowingly become more impaired when consuming similar doses of alcohol (Gilbertson, Ceballos, Prather, & Nixon, 2009, p. 12). MAs may not associate their consumption of alcohol while thinking about the co-morbidities and medication that they take, which can be considered hazardous to their health. Therefore, future research should identify the extent to which MAs participated in dangerous alcohol use behaviors, and what, if any, harmful outcomes this posed to their overall health and ability to successfully age.

Binge Drinking

One-way individuals can abuse alcohol was by binge drinking. Binge drinking was defined as an event in which excessive amounts of alcohol is consumed over a short period, which increased in an individual's blood alcohol content (Mental Health America, 2016). Although binge drinking was commonly associated with adolescents and young adults, per the CDC (2016), binge drinking happened quite often among aging populations, including MAs. Bryant and Kim (2013) explained that oftentimes MAs

choose to drink as a method of self-medication. Bryant and Kim further documented that individuals with psychiatric conditions drink to alleviate the symptoms associated with their disorders. Finally, the authors noted that MAs would drink when they are lonely, have limited social support, are socially isolated, and/or are dissatisfied with their social relationships (Bryant & Kim, 2013).

To best understand binge drinking, it was essential first to understand what was considered moderate drinking. The NIAAA (2016) expressed that a moderate drinker may drink up to one drink per day if she is a woman, and up to two drinks per day if he is a man. Taking this into consideration, the NIAAA argued that to be considered a binge drinker, the individual's blood alcohol consumption level must reach 0.08 g/dl (2016). This occurred typically, within a two-hour timeframe, after a woman had had four or more drinks, and a man has had five or more drinks. The NIAAA (2016) cited an annual survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA). This survey, which is known as the National Survey on Drug Use and Health (NSDUH), defined binge drinking as any drinking that occurs in which five or more alcoholic beverages of any kind have been consumed on the same occasion during at least one day during the past 30 days (NIAAA, 2016).

The CDC, however, reported that binge drinkers who are age 65 years and older, the population that includes MAs, tend to binge drink more often than their younger counterparts (2016). MAs, on average, binge drank five to six times per month, usually consuming eight alcoholic beverages per binge (CDC, 2016). It is important to note that many people who would be considered a binge drinker were not considered to be alcohol-

dependent or an alcoholic (CDC, 2012). In MAs, however, binge drinking did contribute to the worsening of many health problems, some of which were preventable, such as intentional injuries and neurological damage. Although there was evidence available that supported moderate alcohol consumption as a manner to prevent cognitive decline and dementia, little was known about alcohol consumption and performance in various cognitive domains in its users (Gross et al., 2011).

Gross et al. (2011) conducted a longitudinal study over a 17-year timeframe on individuals with an average starting age of 55. This study sought to determine if an association exists between alcohol consumption and domain-specific cognitive abilities in individuals across all levels of drinking (i.e., minimal, moderate, heavy). When the authors controlled for variables such as age, smoking status, sex, hypertension, and other cognitive variables, it was determined that alcohol consumed in higher amounts on a weekly basis along with frequency in an individual's midlife showed a clear association with lowered phonemic fluency. Phonemic fluency was noted merely as an individual's verbal thought processes or letter fluency (Gross et al., 2011). Furthermore, it was determined that low levels of alcohol consumption, as well as those who drank three to four times weekly through midlife and into later life, had the best cognitive outcomes in old age as it relates to their ability to word-find and use their executive functions (Gross et al., 2011).

Zanjani et al. (2013) expanded on the notion that alcohol use affects cognition by conducting a study to determine what an individual's cognitive outcomes would be over time as s/he consumed alcohol based on his/her age. This study included individuals from

three age groups: 45-64 (middle-aged), 65-75 (young-old), and 75 and older (old-old). As coined by McGinnis and Zelinski (2003), individuals aged 75 and older are referred to as "old-old adults" (p. 497). Three levels of alcohol consumption were analyzed for each group: abstinent, moderate (less than seven drinks/week), and at-risk (more than eight drinks/week) (Zanjani et al., 2013). To determine alcohol consumption, the authors analyzed three open-ended questions that were asked of all who completed the SLS Health Behavior Questionnaire. Those questions included: "(1) How many glasses of wine did you drink last week? (2) How many bottles or cans of beer did you drink last week? (3) How many drinks containing hard liquor did you drink last week?" (Zanjani et al., 2013, p. 14). The authors argued that separating the questions related to alcohol use into three separate questions reduced the likelihood that the participants would underreport his/her usage. The authors explained that they used the participants' ages as a categorical value to be able to identify and detect alcohol consumption and cognitive ability patterns across the various age groups as opposed to making implications. Furthermore, the literature on binge drinking concluded that an individual's education, income, and smoking influence their alcohol consumption. For this reason, the authors controlled for these factors as well as gender, age group, and baseline drinking levels.

Zanjani et al.'s (2013) findings implied that an individual's drinking status correlates with a change in his/her verbal ability, spatial ability, and perceptual speed. Zanjani et al. (2013) determined that old-old adults who abstained from all alcohol use, as well as those who had moderate alcohol consumption, had a marked decline in their verbal abilities, while young-old adults across all drinking statuses showed a decrease in

their spatial skills. The authors also concluded that women who abstained from alcohol consumption had a decline in their perceptual speed when compared those women who regularly consumed alcohol, and men across all drinking statues were noted to have a reduction in their perceptual speed (Zanjani et al., 2013).

The findings from Zanjani et al. (2013) elaborated on other cognitive domains such as spatial ability and perceptual speed that were not addressed by Gross et al. (2011). Zanjani et al. (2013) proved that the amount of alcohol that an individual consumes at a specific age affects his/her cognitive stability. This was further in alignment with another study (see Rodgers et al., 2005) that determined that light alcohol consumption (i.e. one drink per day) protects cognition in MAs when compared to their cohorts who either abstain or use excessive amounts of alcohol.

A notable limitation for each of these studies was that participants self-reported their past week's alcohol use, as did participants in Sacco et al. (2015), and, therefore, many of their responses were unreliable (Zanjani et al., 2013; Gross et al., 2011). Although studies conducted by Chu et al. (2010) and Ekholm et al. (2011) have suggested that self-reported alcohol consumption was a reliable method for identifying drinking patterns, it was also indicated in the literature that an individual’s ability to recall past-week drinking habits may not be reliable for sporadic drinkers; those who drink less than four days per week (Gmel & Daeppen, 2007). With the ages of the participants in mind, it was easy to assume that they may not be able to correctly recall the number of alcoholic beverages they have consumed over the past week. The authors noted that the evidence as it relates to a protective effect of alcohol consumption on older adults’ cognition was

inconsistent, and, therefore, reliable recommendations for alcohol consumption among older adults cannot be explicitly determined (2013). Finally, many of the participants in both Gross et al. (2011) and Zanjani et al. (2013) studies were White, highly educated, and financially stable males. For this reason, it may be difficult to discern these results to other demographics of MAs who drink.

Assisted Living and Public Health Issues Related to Aging

The CDC (2013) predicted that by 2030 healthcare-related spending would increase by twenty-five percent primarily because the population is aging. The CDC (2013) explained that healthcare-related costs for one individual age 65 and older are three to five times higher than it is for an individual younger than 65 years of age. Additionally, the CDC found that two out of three older Americans were faced with multiple chronic medical conditions including substance use or abuse, arthritis or osteoporosis, and mental illness, which further drove up the costs of providing medical care (2012). Medicare spending was expected to increase by more than $300 billion by the year 2020 (CDC, 2012). Finally, it was likely that there will be a continued increase in the number of people who, because of declining physical health, will no longer be able to live independently in their own home (Mulry, 2012).

Kozar-Westman, Troutman-Jordan, and Nies (2013) expressed that as individual life expectancy continues to increase, the number of individuals who will require activities of daily living (ADLs) assistance will rise. This resulted in a higher number of individuals who required the need of an ALC. The decision related to moving into an ALC was a life-changing process for both the older adult and their family (Koenig et al.,

2014). It was suggested that by 2050, more than 20 million individuals will require some form of long-term care (Kozar-Westman et al., 2013). Assisted living facilities, which provide a wide range of services, were becoming an increasingly crucial long-term care option for MAs who could live independently but required minimal assistance (Koenig et al., 2014).

Although research that focused on the assessment of successful aging by targeting social isolation in MAs was conducted, (see Dickens, Richards, Greaves, & Campbell, 2011) specific research that related to those MAs residing in ALCs was limited. Research conducted by Ferri et al. (2009) suggested that a relationship exists between successful aging when functional status, life attitudes, perceived support, and continuity is taken into consideration. However, current knowledge about successful aging as it related to the ALC population was vague. Kozar-Westman et al. (2013) attempted to provide clarity to this phenomenon by conducting a pivotal study to determine how successfully "older adults" aged while living in ALCs. For their study, Kozar-Westman et al. (2013) defined "older adults" as all individuals 65 years of age and older (p. 239), which included men and women (age 65-75), as well as older individuals. To conduct this study, the researchers used the Successful Aging Inventory (SAI), the Life Satisfactory Inventory-A (LSI-A), the Purpose in Life Test (PIL), and the Center for Epidemiologic Studies Depression Scale (CESD). Kozar-Westman et al. (2013) recruited participants between the ages of 52-100 for this study.

The results of the study were based on how the participants rated their overall health, ability to exercise, relationship statuses, income, and perceived aging. The authors

noted that most of the participants did not have a partner or significant other, expressed that their health was either good or excellent, and had an annual income of less than $20,000 (Kozar-Westman et al., 2013). The authors did not discuss the participant's ability to afford his/her ALC living arrangement, based on his/her reported income (Kozar-Westman et al., 2013). After an analysis of all scores of the instruments used, the authors determined that successful aging is evident among individuals residing in ALCs (Kozar-Westman et al., 2013). This study suggested that 50% of ALC residents reported that they exercised regularly (Kozar-Westman et al., 2013). These findings were significant and were in alignment with previous research conducted by Chodzko-Zajko, Schwingel, and Park (2009) that proved that a moderate amount of exercise promoted successful aging, and increased life expectancy by limiting the development and slowing down the progression of debilitating conditions. It is important to note that the sample population of the Kozar-Westman et al. (2013) study was not representative of all racial classes or geographical locations. This study was based on a sample population from the southern portion of the United States and was primarily inclusive of Black and White ALC residents (Kozar-Westman et al., 2013). For this reason, it may difficult to distinguish successful aging discrepancies among culturally and ethnically diverse populations of older adults.

Based on the literature reviewed, it was clear that MA ALC residents were an under-investigated population. Although Kozar-Westman et al. (2013) analyzed a few of the variables associated with successful aging among this population, there were other variables that must be examined to assess whether individuals can thrive in their current

living arrangement. One important variable which was often overlooked when MAs in ALCs were studied was their misuse and abuse of alcohol. There was information available on alcohol use and abuse by MAs in other long-term care settings, such as public housing, but data in environments such as ALCs was limited (Sheehan, 1997). Castle, Wagner, Ferguson-Rome, Smith, and Handler (2012) expressed that alcohol misuse and abuse among the elderly, which they defined as adults aged 65 and older, is said to be an "invisible epidemic" (p. 322). Alcohol abuse in MAs should be a priority area of study, as this public health issue will become larger as the population grows. Furthermore, an in-depth investigation into the effect of interventions that promote successful aging of aging adult ALC residents is needed.

Castle et al. (2012) conducted a study in which they evaluated alcohol misuse and abuse of MAs in Pennsylvania as reported by assisted living nurse aides. The authors noted that even though they assessed the frequency of alcohol consumption among ALC residents, they did not examine the quantity and type of alcohol the ALC resident consumed. Of note, Klein, and Jess (2002) asserted that individual nursing homes and ALCs have different policies and procedures that are related to alcohol use by their residents. Some facilities, to keep the MAs' lives as similar to pre-ALC days, may offer cocktail hour and allow residents to have alcohol in their rooms/apartments. Castle et al. (2012) found that 69% of ALC residents consumed alcohol. Furthermore, of this reported number, nurse aides recorded that 34% of their ALC residents drink daily (Castle et al., 2012).

Castle et al. (2012) additionally determined that the side effects related to alcohol misuse and abuse by those aged 65 and older who live in ALCs can be detrimental, mainly when they mixed alcohol with prescription medication. With alcohol misuse and abuse in mind, 44% of the nurse aides speculated that some of the residents that they care for make poor alcohol consumption choices (Castle et al., 2012). The study found 40% of nurse aids observed or cared for an ALC resident who was under the influence of alcohol (p. 328). These values, as argued by the authors, showed that while 19% of the reported cases have had their health comprised based on their alcohol consumption, it was believed that more ALC residents had made poor alcohol consumption choices (Castle et al., 2016, p. 330).

Castle et al.'s findings supported that alcohol misuse and abuse by elders residing in ALCs was a public health issue. Such studies should be analyzed more closely as ALC residents' quality of life and safety are significantly affected by their alcohol consumption (2012). The values the authors reported might not completely discern the amount of alcohol being consumed by ALC residents (Castle et al., 2012). Furthermore, while Castle et al. examined the alcohol consumption of residents in ALCs, they did not determine whether these residents were exposing themselves to other alcohol-related risks including mixing their prescription medications with alcohol and/or driving while under the influence of alcohol (2012). Basca (2008) suggested that most individuals 65 and older took three or more prescription medications daily. Therefore, the potential for MAs residing in ALCs mixing alcohol with prescription medication was high and potentially dangerous.

This literature review uncovered some surprising gaps in the published, peer-reviewed research. The most significant surprise was that most studies did not directly include any ALC residents, regardless of age. Additionally, it appeared that very few male nurse aides were included. Although the most substantial number of nurse aides as reported by the CDC (2008) are women (92%), the observations and opinions of the male nurse aide (8%) population were warranted. Therefore, this literature review identified the need for more research; such an investigation would yield stronger detection and management training for staff by including research on both MAs residing in ALCs and consume alcohol and male and female caregivers of ALC residents. As evidence suggested, the aging population in ALCs will continue to grow into the foreseeable future. Thus, it was imperative that public health research is undertaken to address alcohol abuse in ALCs.

Issues Related to Aging

Public Health Issues of Aging Populations

The 2010 U.S. Census Bureau explained that baby boomers constituted 30% of the total U.S. population, and the first members of this generation began turning 65 in 2011 (Kuerbis & Sacco, 2012). As this generation ages, McGinnis and Zelinski (2003) found that more public health issues will surface for young-old adults, which also includes the MA population. Since baby boomers have reported an historically elevated rate of alcohol use throughout their adolescence and adult lives, as this generation ages, there is an increased public health concern that this group's consumption of alcohol will continue to grow and be considered unhealthy (Sacco et al., 2014). Additionally, aging

populations tended to experience an increase in mortality due to isolation and loneliness, the use of alcohol and prescription medications, and decreased brain functioning (Sacco et al., 2014). As MAs increase in age, the public health concern was that this population alcohol consumption and social isolation will lead to more alcohol consumption. If they combined these issues with alcohol, experts believed MAs may experience more negative health issues.

Finally, the literature found another issue that plagued our aging populations: maintaining their mental and behavioral health. The American Psychological Association (2016) suggested that at least 20% of adults aged 55 and older are affected by a mental health disorder, but less than three percent of this population admit to seeking professional treatment. Psychological and behavioral health problems in this population stemmed from a variety of occurrences. However, the most common reasons for mental and behavioral health issues in aging populations included the loss of a spouse, loss of mobility and independence, admittance in long-term care (nursing homes or assisted living facilities), and an overall decline in his/her physical health (American Psychological Association , 2016). Furthermore, the most common mental and neurological disorders among this age group were dementia and depression (World Health Organization (WHO), 2017).

The American Psychological Association reported that two-thirds of those individuals residing in a nursing home for long-term care were said to exhibit mental and behavioral health problems (2016). Since many residents in assisted living later moved into a long-term care like a nursing home when their health declines, it can be assumed

that a large percentage of ALC residents exhibit mental and behavioral health issues as well (American Psychological Association, 2016). However, since many assisted living and nursing home facilities employed staff that was unfamiliar with geriatric health care, the American Psychological Association found that the many residents were not receiving the treatment that they so desperately need (2016). The American Psychological Association (2016) suggested that, often, mental, and behavioral health problems in older adult's mimicked and even coincided with other medical illness or life-changing events, which can be overlooked for this reason. To alleviate the concerns in this area, the American Psychological Association suggested that, before choosing an assisted living or nursing home facility for long-term care, older adults and/or their families should receive assistance in finding a facility that employed trained geriatric specialists. To find facilities that employed such trained geriatric specialists, families can review facilities selected through the selected states assisted living association or the Medicare website for nursing home facilities.

Caregivers of Mature Adults (MAs)

Once an individual or his/her family decided that s/he will reside in an assisted living care setting, the process to complete this transition was not entered lightly. Previous research had suggested that providing care to an impaired MAs can be detrimental to the overall health and well-being of a familial caregiver (see Abell & Gecas, 1997). It was further suggested that 80-90% of familial caregivers were often the primary source of support and direct care for their loved ones (Sanderson & Meyers, 2004). Not only were familial caregivers a primary source of help, but they also supply a

good amount of socialization for the loved one for whom they provided care (Sanderson & Meyers, 2004). The familial caregiver was a role that required commitment, and, for many, the familial caregiver's emotional state took a psychological toll on performing this work (Sanderson & Meyers, 2004).

In a study conducted by Sanderson and Meyers (2004), the emotional experiences of familial caregivers of MAs were examined both during and after they decided to place their loved one in a long-term care facility (i.e., ALC). The authors used data that was collected from sixteen familial caregivers of MAs residing in ALCs in Southern California. Each of these ALCs was in upper and middle-class income areas within a 25-mile radius of one another. The familial caregivers were inclusive of sons, daughters, spouses, daughters-in-law, and a granddaughter (Sanderson & Meyers, 2004). Fifteen of the participants were noted to be Caucasian while one participant was of Hispanic descent (Sanderson & Meyers, 2004).

The study found that the participant’s responses were closely aligned with one another as many of the familial caregivers reported similar experiences with their decision to place their loved one in an ALC (Sanderson & Meyers, 2004). The authors said each participant experienced a wide range of emotions throughout the placement process, including but not limited to guilt, anger, sadness, and happiness (Sanderson & Meyers, 2004). Additionally, the authors also found that a few familial caregivers reported a sense of wanting to do more for their loved ones as opposed to merely placing them into an ALC (Sanderson & Meyers, 2004). Of the familial caregivers who reported a sense of wanting to do more, many decided that an ALC was the preferred option as

they neither wanted the daily responsibility of serving in a caregiving role nor did they want to sacrifice their freedom (Sanderson & Meyers, 2004). Although an ALC was chosen as the best option for their loved one, many of the study participants often visited, assisted with activities of daily living for their loved one, and usually provided transportation of their loved ones to doctors' visits (Sanderson & Meyers, 2004). Furthermore, each study participant reported feelings of relief after placing their loved in into an ALC because s/he knew that s/he would be receiving 24-hour supervision and would be able to foster new relationships with age-appropriate peers (Sanderson & Meyers, 2004).

These findings shed light on the emotional experiences faced by familial caregivers as it relates to the placement of their loved one into an ALC. Participants in this study expressed a moral commitment to caring for their loved ones, and they further explained that, in many instances, they believed that providing this care was a requirement, and not a choice (Sanderson & Meyers, 2004). This study was not without apparent limitations, with the most prominent one being sample size. The sample size of this study was small, financially affluent, and set in one geographic area of Southern California, which limited the generalizability of the study's results (Sanderson & Meyers, 2004). Furthermore, participants were in the upper and middle-income classes, so this study eliminated the lower income group and the financial strains associated with placing family members in ALCs. Future studies should address a larger sample size in a more balanced socio-economic group of familial caregivers from a broader geographical region to see if similarities occur.

Family Issues with Aging Populations Residing in Assisted Living Communities

Gaugler and Kane (2007) cited two manners of long-term care are described in the United States: formal, which includes paid care providers, and informal, which is usually carried out by an unpaid family member. The decision to place a loved one into an assisted living facility was not one that should be entered lightly. There may be medical, emotional, and physical events that occurred that may expedite this decision, but it was often the MAs' decision that this is the lifestyle that they would like to lead based on their family dynamics. It must be remembered that there was an adjustment period that took place once a move of this nature occurred, and MAs may face a series of disturbances in their behaviors, including grief, impaired functioning, or even elevated mortality rates (Junger, 2010). Once MAs entered assisted living, many have transitional issues from having complete autonomy before entering the community to living in a community that had rules in which they may not be accustomed to having to follow.

Gaugler and Kane (2007) argued that there has been little exploration of the social ramifications that were faced by older adults and their family members as they transitioned into ALCs. The authors identified 180 studies that focused on ALC issues related to families or informal care and reviewed the literature available between December 2005 and January 2006 (2007). The authors examined the following databases: Medline, PsycINFO, and CINAHL. To be included in this study, the article had to discuss "family structure in AL[C], types and predictors of family involvement in AL[C], and family-related outcomes" (Gaugler & Kane, 2007, p. 85). Studies that used a convenience sample of the ALC residents were excluded, and those studies that reported data on at

least two of the identified variables were included. Furthermore, the authors added those studies that had a specific sampling frame of ALC facilities and residents on a national, state, multiregional and regional level. Of the 180 studies identified, Gaugler and Kane (2007) included results from 62 of them in their research.

After a review of the literature, the authors identified two trends related to the informal care available to individuals in ALC. It was determined that "70% or more of AL[C] residents are widowed, and few AL[C] residents, 7% or less, are living with a spouse in an AL[C] facility" (Gaugler & Kane, 2007, p. 86). For those who were not married and who had no family support available to them, it was discovered that their personal needs were being met via the formal support available at the ALC (e.g., personal care staff in the assisted living), or by the informal resources available externally (e.g., home health care services/community support). From the literature, the authors were also able to distinguish that the average age of the ALC resident was at least 80 years, with many being 85 years of age and older (see Hawes, Phillips, & Rose, 2000). Of those octogenarians, 20% suffered from severe cognitive impairment, and 20% depended on others for assistance with three or more of their ADLs (Gaugler & Kane, 2007).

Family involvement in ALCs is essential as it can serve as a supplement to the formal care that is offered in ALC. The authors quantified family involvement by the number of visits made to the ALC by the family members and what the family members did for the resident while present (Gaugler, & Kane, 2007). The authors reviewed the available, qualitative, and quantitative literature and found the primary focus of the quantitative research was on visits or frequent contact (e.g. telephone calls). They

concluded that there was a high degree of family involvement with the ALC, and the residents received regular phone calls (e.g. once weekly, or more) as well as in-person visits (Gaugler & Kane, 2007). The authors expressed that the resident's family one to three times provided necessary care monthly, but they spent one hour or less monthly providing ADL assistance. Further, the study highlighted that most often, ALC residents reported that their families were highly supportive from a socioemotional standpoint (see Keating et al. 2001). It is important to note that the authors expressed that there was a limited amount of research that was available concerning monitoring and advocacy for ALC residents by their family members. Port et al. (2005) uncovered that some families engaged in frequent medical and financial monitoring of their loved ones in ALC at a rate of five times monthly.

From a qualitative perspective, Gaugler and Kane evaluated 62 of the 182 identified studies of semi structured interviews with six to 78 family members in several types of residential care settings throughout the United States and abroad (Gaugler & Kane, 2007). These studies determined the level of family involvement that was present. Six of the studies gathered data from multiple information sources along with participant observations (2007). The authors concluded that the qualitative studies results were closely aligned to the quantitative studies as family members engaged in socioemotional forms of assistance such as visits and regular contact and were active in monitoring and attempting to preserve the well-being of ALC residents (Gaugler & Kane, 2007). The primary differences in the qualitative and quantitative studies showed that in the qualitative studies' family members were less likely to perform personal forms of care

assistance and instead allowed the ALC or outside care providers to perform these tasks for residents. Additionally, the authors reported that the qualitative studies explored themes related to the importance of

> prior-family resident relationships in dictating the quality and type of family involvement (Sanderson & Meyers, 2004), the role of family-oriented facility characteristics, environment, and policies in affecting family inputs in care planning and decision making (Carder & Hernandez, 2004), and deviant family caregivers, or those who prefer to operate outside of group norms of family involvement and care (Perkinson, 1995) (Gaugler & Kane, 2007, p. 92).

From the information reported, it was difficult to discern whether formal or informal care was the best type of care, as well as how much involvement from the family was necessary for the resident to thrive in their ALC. What could be determined from this research was that family involvement at various transitional stages into ALC was important as this was a recurring theme. Gaugler and Kane's review was only a stepping-stone as it related to the research that should take place where family involvement in ALC is concerned. As explained by Gaugler and Kane, it was difficult to identify what the "casual direction of family involvement and potential predictors" were because there was a lack of longitudinal research available (2007, p. 95).

Summary and Transition

As expressed by Castle et al. (2012), the literature documented over the past decade that ALCs have been the primary residence of choice for MAs who required some assistance with their ADLs and who may or may not have the amount of family

involvement that they would desire. What has not been appropriately addressed by the literature were the perspectives of familial caregivers of MAs as it related to their alcohol use in ALCs. Furthermore, there were missing elements regarding public health policy implications that have been put in place by ALC administration to address alcohol use by MAs residing in such facilities. This dissertation addressed the effect, if any, that alcohol use has on the MAs' ability to successfully age in their ALC based on the perspectives of their familial caregivers.

In determining the success of MAs' ability to age in an ALC, the Life Course Health Development (LCHD) model provided information on how health trajectories insights were developed for individuals over their lifetime. Under the LCHD model, the knowledge that was taken from this idea assisted with the overall development of new policies and research, specifically within the field of public health. This dissertation study examined MAs residing in assisted living use and/or abuse of alcohol as reported by their familial caregivers. Then this dissertation study discussed how these MAs adjusted to the public health issues related to aging among this population and, more importantly, how alcohol affected this population's aging processes.

The next chapter discusses the methodologies that were used to understand how MAs residing in assisted living use and abuse of alcohol, and what, if any, effects it had on their ability to successfully age in their assisted living environment. This study examined those closest to MAs: their children or other familial caregivers (e.g., niece). This study addressed alcohol use among MAs at various ALCs through face-to-face and telephone interviews that were conducted with their familial caregivers to discuss

whether alcohol use affected MAs' ability successfully age in their ALC. Chapter 3 will also provide information on the study's methodology, how the participants were identified, the research questions that guided the study, and the interview questions that were asked of the children/relatives of the MAs. Finally, Chapter 3 addresses how the information was organized and later analyzed in Chapter 4.

Chapter 3: Research Method

Introduction

The purpose of this study was to understand how MAs residing in ALCs use alcohol, and what, if any, effects such alcohol use has on their ability to successfully age in their assisted living environment. The chapter outlines the study's research method, the participant selection process, the role of the researcher, the measures taken to protect the study's participants, the manners in which data were collected, and the data analysis procedures.

Research Design and Rationale

This research study addressed the following qualitative questions:

RQ1: To what extent do daily experiences in assisted living communities result in alcohol use by MAs, as perceived by their familial caregiver?

RQ2: Do loneliness or social isolation, as perceived by the familial caregiver, affect the ability of the MAs to age successfully in place in the assisted living community?

RQ3: What emotional, physical and social challenges do familial caregivers perceive their MAs parent/relative face by consuming alcohol in the assisted living community?

RQ4: How do the familial caregivers of MAs describe the alcohol consumption of their MAs parent/relative in the assisted living community?

The phenomenological design was selected to examine the public health issues faced by MAs who reside in ALCs and consume alcohol based on the perspectives of

their familial caregivers. This study examined a population of participants who have parents/relatives in ALCs in the United States. The familial relationships included both genetic relationships and relation by marriage. Each familial caregiver had an awareness of the MA's consumption of alcohol both in their current ALC setting and prior to their loved one entering the ALC.

Initially for this study, I selected urban areas of Alabama, and chose Birmingham, Montgomery, and Tuscaloosa as they are three of the largest cities within the state and would most likely produce a robust selection of familial caregivers for participation in this study. After several months of heavy recruitment, I was unable to recruit any participants from this selected area and chose to open the study up to the entire United States. This study provided an opportunity for the familial caregiver to disclose their perceptions of the MAs' alcohol use in their own words. The objective of the study was to explore the public health issues faced by the MAs alcohol users, and how their familial caregivers perceived this alcohol use affects the MAs' ability to successfully age in place in their ALCs.

One of the more prominent purposes was to provide the researcher with an alternative means by which to view and analyze a complicated problem or social issue (Reeves et al., 2008). Edmund Husserl was credited with the development of the phenomenological approach (Reeves et al., 2008). This approach was created to provide individual based meanings to the social phenomena faced in the individual's everyday life (Reeves et al., 2008). For the population under study, their individual experiences and perspectives were the essence of what is being researched.

Phenomenology provided a clearer understanding of the facts by presenting information that was often already known, but it was still relevant in relation to the phenomenon in question (Starks & Trinidad, 2007). The phenomenological approach suggested a common meaning derived from the perspectives and experiences expressed by the familial caregivers of MAs in relation to their description of the phenomenon of alcohol use in an ALC. It was these lived experiences that provided meaning to the familial caregiver's perception of the phenomenon under study and, accordingly, helped the MAs identify what was real in his or her life. This approach was best, as it afforded the researcher with an opportunity to understand lived human experiences. With the phenomenological approach, the researcher was able to clarify the meaning behind a specific phenomenon as opposed to merely explaining or attempting to discover a cause (Penner & McClement, 2008).

Before selecting the phenomenological approach, other qualitative methods of inquiry were explored but were considered less practical for use. For example, a discourse analysis attempted to evaluate how an individual accomplishes social, personal, and political ventures through their use of language (Starks & Trinidad, 2007). This method of inquiry traced the historical evolution of language practices along with examining how individual language shapes and reflects cultural, social, and political practices (Starks & Trinidad, 2007). This method of inquiry would do little for this study. Primarily, it is language specific, and, although it could highlight how personal and group identities were formed in settings such as ALCs, it would not explain how alcohol use affected the overall public health issues faced by MAs in settings of this nature.

Another qualitative method of inquiry explored was grounded theory. This theory examined the six C's of the social process—causes, contexts, contingencies, consequences, covariances, and conditions—to best understand what patterns and relationships existed among these methods (Starks & Trinidad, 2007). This thorough approach used careful observations of individual behavioral patterns. However, this approach may not be as effective with familial caregivers of MAs, the chosen population of this study, for this reason. This research gathered all information from face-to-face and telephone interviews, including any minor behavioral observations, with the subjects.

Therefore, after reviewing several research methodologies, I determined the phenomenological approach as the most direct and effective manner to explore this research study. Use of this approach was based on trying to understand the experiences of the familial participants as it relates to the phenomenon under study—MAs' drinking habits in ALCs and how it impacted their aging in place—as the familial participants were the core of the research conducted (Starks & Trinidad, 2007). By using the phenomenological approach, the researcher was provided with the flexibility to explore the various facets of one phenomenon from the perspectives and experiences of the familial caregivers who are closest to the MAs in ALCs.

Role of the Researcher

As suggested by Xu and Storr (2012), the qualitative researcher played an integral part in both generating and interpreting data. Hoepfl (1997) explained that the primary function of the qualitative researcher was to have the insight and ability to discern the information that is considered pertinent to that which is not. For this study, I was

responsible for identifying and soliciting participants, distributing, and collecting data, examining the participants' responses, and identifying research trends. As a qualitative researcher, I focused on exploring, examining, and describing the participants' perspectives and experiences of MAs who resided in an ALC and consumed alcohol through the lens of their familial caregivers. Additionally, I was also responsible for gathering, sorting, categorizing, coding, analyzing, interpreting, and securely storing the collected data. Each participant's interview was transcribed by a professional transcription service, Tybee Types. Furthermore, as the interviewer, I was responsible for developing open-ended, semi-structured interview questions to ensure that the participants could provide in-depth responses. Notes were taken during each interview, and participants were informed that breaks were allowed if they felt the need to take one. Also, the participants were reminded that they could refuse to answer any question and opt out of the study at any time without any penalty to the participant and/or their MAs family member.

The MA population in the United States rapidly grew, and, whether by choice or by force, many MAs moved into ALCs, which afforded many the ability to maintain a sense of normalcy. Being aware of these circumstances enabled me to consciously categorize my beliefs so that I could make a clear assessment of the MAs' current status based on the perspectives of their familial caregivers.

I currently work as the Market Director for the Behavioral Health Service Line for Brookwood Baptist Health in Birmingham, Alabama. In this role, I am responsible for coordinating and evaluating all mental health related services provided by our five-

hospital system. In my position, I actively seek new service line strategies and opportunities to expand client care services, ensure that appropriate objectives are established for each market hospital. I coordinate service line specific activities with other constituencies both within and outside of the market hospitals, being aware of service line trends as it relates to admissions and financial feasibility by advocating for the appropriate use and reimbursement of mental health services on a local and state-wide basis. In my role, I actively participate in the market strategic and operational objectives for the mental health service line and monitor results in addition to various other responsibilities.

Although I have had a working relationship with both skilled nursing and ALCs throughout the state of Alabama, I had no professional relationship with the potential participants. Therefore, no conflicts of interest influenced this study. This study included one population: the familial caregivers of MAs who consumed alcohol and resided in an ALC at the time of this study. Every precaution was taken to ensure that all study participants felt safe and comfortable; additionally, each participant understood that she had the liberty to withdraw from the study at any time. Finally, I maintained a research journal to provide my reflections as they related to this study to prevent biases and assumptions in data collection.

Methodology

Participant Selection Logic

The primary population under study consisted of only women defined as the familial caregivers of MAs who consumed alcohol and resided in ALCs at the time of the

study. The study was open to both male and female participants, and one male was pre-screened for the study, but ultimately determined to be ineligible as his loved one did not meet the set age parameters for study inclusion. The participants' MA relatives were residents in ALCs in various facilities throughout the United States. However, of the familial caregivers, seven resided in cities throughout the Southwestern portion of the United States and one was from the Midwest. Seven of the familial caregivers were near enough to regularly visit their MA family member. Gaugler and Ewen (2005) argued that there has been little exploration into the social ramifications that are faced by aging adults (including the MA population) and their family members as they transition into ALCs. They concluded that there was a high degree of family involvement in the ALC, and the residents received frequent phone calls (e.g., once weekly, or more) as well as in-person visits from their family members (Gaugler & Ewen, 2005). Further, Gaugler and Ewen (2005) highlighted that assisted living residents reported that their families were highly supportive from a socio-emotional standpoint (see Keating et al., 2001). For this reason, it was acceptable to use this population of individuals to further delve into the public health issues surrounding ALC resident MAs' consumption of alcohol.

Alcohol consumption in the United States often caused several problematic issues such as alcohol use disorders, alcohol-related deaths, economic burdens, and other associated consequences (e.g., medical issues, an increase in alcohol-related falls, etc.). As such, a wealth of research dedicated to alcohol consumption and abuse had been published. I completed a careful review of the literature using these key terms: assisted living, alcohol abuse and binge drinking, public health issues related to aging

populations, life course health development model and aging populations, race and/or ethnicity issues in aging populations and/or aging populations, caregivers of aging adults and/or aging populations, and family issues with aging populations. The results from the literature review which used those key terms found only a few peer-reviewed studies which focused on alcohol use in the aging adult population, which includes the MAs population (see Zanjani et al., 2013; Sacco, Bucholz, & Harrington, 2014; Blazer & Wu, 2009a). Therefore, I found that there was a need for more peer-reviewed studies on this subject matter and believe that this dissertation study could add to this lack of literature on the subject.

As MAs continued to grow as a segment of the population, more public health issues among them will surface. Some of the public health issues faced by MAs directly related to their use and abuse of alcohol. For inclusion in this study, the familial caregiver participants had to meet all the following criterion:

1. Have a familial caregiving relationship to a MA, aged 65 and older who resides in an ALC in the United States. This relationship does not have to be genetic.
2. Have an awareness of their MAs' consumption of alcohol in their current ALC setting.
3. Not have a MA parent/relative diagnosed with a cognitive impairment or a diagnosis of Alzheimer's or other dementia-related diseases and/or be receiving medical treatment for Alzheimer's or other dementia-related diseases per self-report.

I pre-screened each potential participant to determine his or her eligibility for participation in this study.

Creswell (2013) stated that the phenomenological approach could be satisfactorily carried out with five to 25 participants. Some qualitative research employed a concept known as purposeful sampling. This type of sampling was when the researcher selected his or her participants based on their ability to purposefully create insight into the phenomenon under study (Creswell, 2013). In following these recommendations, and with purposeful sampling in mind, this study randomly recruited participants and pre-screened them to make sure they fit into the parameters defined, with an initial goal of identifying 15-20 participants. After 16 months of valiant recruitment efforts and several requests to change the initially defined inclusion criteria, I was only able to obtain consent and interview eight participants. There were 13 individuals pre-screened for this study and five were unable to participate as they did not fit within the defined parameters for study inclusion.

Recruitment for this study was low, so snowball or chain sampling measures were undertaken with the participating familial caregivers of MAs. This method was described as one in which current participants identify or recommend other potential participants who may be appropriate for the study (Waters, 2015). Waters explained that this technique was effective more often when the phenomenon under study is considered highly sensitive or when the population under study is difficult to reach (Waters, 2015). Snowball sampling, as further noted by Waters (2015), was interdependent of the researcher, which meant if the researcher was unable to build trust with the study's

population then the research being conducted may be affected. Through this method of sampling, I was able to identify four additional study participants, based on the recommendation of four of the previously participating participants. The additional participants that were found through snowball sampling were determined to have met the requirements for the study through prescreening. Also, participants found through snowball sampling provided consent before participating in the study.

Another important consideration of this research study was the sex/gender of the study participants. Runnels et al. (2014) said that when researchers fail to consider the sex or gender differences of their study population, the study could yield inappropriate or irrelevant findings which would make it difficult for individual health policies or programs to be successful for different sexes or genders. While it was preferable to have the perspectives divided equally between men and women familial relations, the researcher decided that participation in this study would not be limited by the participant's gender, however, of the thirteen prescreened participants, only eight qualified and consented to the study, all of whom were female participants. Since most caregivers are female, according to the Family Caregiver Alliance (2012), this study corresponds to the norm; however, having men participate in this study may have yielded different findings. Although research that represented both genders is valuable, the challenges that may arise in finding a gender balance may have hindered the completion of the proposed study (Runnels et al., 2014).

Qualitative research involved saturation which occurs when collecting data that no longer presented any new ideas or additional themes (Dworkin, 2012). Morse (1995)

further explained that researchers primarily determine saturation while analyzing their current results and developing themes. One point that should be considered while conducting qualitative research is that "more data does not necessarily lead to more information" (Mason, 2010, p. 1). For this reason, once patterns and themes began to make sense and can no longer be elaborated on, saturation has occurred.

Instrumentation

There were various tools available to collect qualitative data. Creswell (2013) explained that, although phenomenological research primarily used interviews with those individuals who have experienced the phenomenon under study, observation with other tools of collection could also be used. For this study, I chose to conduct individual, in-depth, semi structured, face-to-face and telephone interviews, using a self-designed questionnaire, to explore the topic of study. Edwards and Holland (2013) described this form of data collection as flexible and noted that this gives the option of being flexible as it related to how they state their questions for a dialogue to ensue. Furthermore, individual, in-depth, semi structured, face-to-face and telephone interviews afforded the opportunity to assist the study participants with reconstructing the events that they were recalling, to gain a better understanding of their experience with the phenomenon under study (DiCicco-Bloom & Crabtree, 2006). I continued to interview participants until no new participants presented for participation in this study.

To conduct the face-to-face and telephone interviews, a self-designed, informal questionnaire was used. This instrument was approved by the dissertation committee and Walden University's IRB. Self-development of qualitative research instruments was not

an uncommon notion but, good research questions do not always yield good research results (Agee, 2009). Qualitative inquiry is reflective; thus, I was able to construct questions that identified what was intended to be uncover from those who were being interviewed (Agee, 2009).

Sound qualitative open-ended questions opened an avenue of discovery and allowed the participants to respond accordingly (Agee, 2009). Consideration was made for the questions that were asked and the effect that they may have on the lives of the participants (Agee, 2009). For the familial caregiver participants, the questions consisted of the following categories: questions directed to build rapport, specific questions that addressed the perceptions of the challenges that are faced by MAs, questions related to the LCHD model questions related to exit and debriefing (see Appendix B).

Prior to solidifying the research questions that were asked of the participants, an expert panel was created to review the questions that were designed; the group was composed of one licensed medical social worker, one geriatric psychiatrist, and one assisted living administrator. As explained by Wu and Lu (2014), expert panels were predominately created in qualitative research when the researcher was interested in clarifying the scope of their research along with ensuring that their research instrument measures the primary objectives of the study. These participants were not randomly selected. Each had experience from both a professional or personal level of alcohol consumption and how it affected their MAs' ability to successfully age. The feedback from these selected panelists was as follows: one panelist inquired as to why a question was not added as to the amount each MA is consuming. I clarified that it would be

difficult for the respondents to address this question if they are not present during each individual consumption. Questions were noted by the expert panelist to be thorough and well-rounded. It was expressed that they should yield adequate information to address my research concerns.

Finally, it was the initial plan to test the interview questions, by conducting a pilot test. Pilot testing, as described by Creswell (2013), was a method in which the researcher refined their research instrument to determine the degree of potential observer bias along with their plan to improve the instrument for data collection. Such a method allowed the researcher a protocol for "developing more relevant lines of questioning" (Creswell, 2013, p. 165). With the number of procedural changes and the inability to recruit the originally desired number of participants, pilot testing was not done.

Procedures for Recruitment, Participation, and Data Collection

The familial caregiver participants were recruited through a Walden University IRB approved flyer (see Appendix C). No data or information was collected for this study prior to approval from Walden University's IRB. The flyer included my contact information in which potential participants could contact me and state their participation interest. The flyers describing the proposed study were distributed to ALCs throughout the United States and their assistance was requested in posting the study information in their respective community for potential participants to view. Before this posting occurred, verbal consent was received from each ALC administrator. Many of the contacted ALCs refused to allow the recruitment flyer to be posted in their community but agreed to mention it during monthly facility meetings with familial caregivers. Also,

for recruitment, study information was displayed in approved public locations in or near ALCs in Birmingham, Alabama. These sites included local libraries, grocery store chains, senior centers, churches, local Al-Anon meeting locations, local restaurants and the local Young Men's Christian Association (YMCA). Prior to posting, verbal consent was received from each location's manager or director, where necessary. Lastly, I also posted the study information, with IRB approval, to Walden University's Participant Pool, shared the study information with Clair Ricewasser, Public Relations Officer with corporate Al-Anon, and posted it to my personal LinkedIn and Twitter accounts.

Prescreening for this study took place via telephone prior to study participation. Interested parties chose to consent to a prescreening interview verbally (see Appendix A). Once it was determined that the participants met the study's requirements, they provided written consent for participation in the study once they deemed it appropriate and expressed their interest. Formal permission to participate took place during the scheduled interview time, which was after the participant received, reviewed, and signed that participation consent form.

Interested familial caregivers of MAs were required to meet the following criteria:

- be a familial caregiver of a MA aged 65-85,
- have a MA parent/relative residing in an assisted living community in the United States
- not have a MA parent/relative diagnosed with a cognitive impairment or a diagnosis of Alzheimer's or other dementia related diseases and/or be

receiving medical treatment for Alzheimer's or other dementia-related diseases per self-report.

For those familial caregivers who met all the above criteria, I conducted a prescreening interview and consenting process for those qualified, interested participants. My initial desire was to select up to 20 familial caregivers of MAs to participate in the actual study of face-to-face or telephone interviews, but, despite my efforts, I was only able to recruit eight who qualified and agreed to participate. There was one in-depth, semi structured, face-to-face or telephone interview conducted with each familial caregiver participant. Telephone interviews were scheduled in the privacy of my home where participants were asked to pick a quiet, private location. Seven of the interviews took place via telephone and were conducted in the privacy of my home. The one face-to face interview was conducted in my office after normal business hours. The interviews lasted 45-60 minutes, and study participants were given a $100 Visa gift card incentive for participating in this research study. Information concerning the incentive was listed on both the study's flyers and the participant consent forms. The incentive was given as a token of appreciation for their participation in this study. Participants were given an option to decline this incentive, however, no one did.

Prior to conducting the study interview, each participant was asked to review and sign the consent form, which included information related to their consent to have their responses, and each participant was subsequently provided with a copy of their signed consent form for their records. Finally, all questions or concerns posed by the consenting participant were addressed prior to scheduling an interview time for the study. The only

question that was presented was related to the likelihood that their loved one would be removed from their ALC because of the caregiver's participation in this study. Two of the consenting participants who posed this question were assured that their loved one's facility would not be aware of their participation in this study. Each participant has been provided with a unique pseudonym identifier which will be used on all their material throughout the study process to ensure confidentiality and protect everyone's identity.

The recorded responses were transcribed using the transcription service Tybee Types. With this transcription service, I uploaded each recorded interview to a password protected website from which the transcriber downloaded said interview and sent the transcribed results to my Walden University email address. In coding, as suggested by Campbell et al. (2013), the researcher strived to develop coding patterns that were reproducible. It should be noted that this sometimes presents with difficulty as the collected data does not always take on the form of "a clearly standardized set of measurement" (Campbell et al., 2013, p. 296). Transcription, as explained by Bailey (2008), can be conducted by many individuals, and may include a junior researcher. In choosing to have my audio recordings transcribed via a transcription service, it was expected that the essential details of each interview will not be missed, and they were not. The transcriber was able to easily transcribe the recordings and clearly identify and document what was stated by the interviewer and respondent. As expressed by Bailey (2008), researchers must be able to carefully observe the data that they are transcribing, careful not to miss important details during this important first step in the data analysis.

Once the recordings were transcribed, I examined each transcription for developed themes and validated each theme via the chosen validation procedure.

Audio recordings were conducted during each face-to-face or telephone interview. Research conducted by Henry et al. (2015) suggested that some individuals are uncomfortable with the notion of being audio recorded and, as a result, this may result in study selection bias. An alternative explanation, offered by Al-Yateem (2012), disclosed that audio recording during qualitative interviewing could benefit the researcher. One of the opportunities it afforded was the ability to repeatedly listen to the audio recording while comparing what the researcher hears to their field notes and subsequently developing stronger themes for their research (Al-Yateem, 2012). The participants had prior knowledge of the audio recordings as it was included on the consent form. Each audio recording was clearly labeled with the time, date, interviewer, and participant identifiers. None of the consenting participants appeared or expressed any concerns about being audio recorded. At the conclusion of the interview, time was allotted to answer any remaining questions that the participant may have had as it related to their participation in this study. Most expressed a keen interest as to why I chose this topic to research and other expressed some of the emotions that came up for them by participating in this study. Participants were reminded that if they felt they would not be able to effectively handle the emotions that were present, a referral could be made for them to speak with someone at their local crisis center, as was written in their consent form. Time was also allotted for each participant to review the transcriptions after they were transcribed to correct any incorrectly transcribed comments or to clarify a point that the participant did

not make clear in the face-to-face or telephone interview. None of the participants accepted this offer, but all expressed that they would like to be made aware of the overall findings from the study.

Data Analysis Plan

Creswell (2013) described data analysis as the process in which collected data was prepared and organized before being analyzed and placed into themes via a method known as coding. According to DiCicco-Bloom and Crabtree (2006), it was ideal for data analysis to co-occur to when it was collected so that the researcher could identify an understanding as it related to the questions being asked. With the phenomenological approach, data analysis began with a description of the personal experiences as provided by the familial caregivers of MAs in relation to the phenomenon of alcohol consumption in ALCs. Prior to the face-to-face or telephone interviews, I explained to the participants what the literature suggested about this phenomenon. In Chapter 4, I described what, according to the participants, were the MAs' experiences with the proposed phenomenon. Following this, I described how the phenomenon was experienced by the MAs and end with an in-depth explanation of the "what" and "how" of the MAs' experience with the phenomenon under study, according to the responses of the familial caregivers (Creswell, 2013, p. 194)

In order to complete the data analysis, hand-coding is the most effective method. By coding the data by hand, I was able to carefully examine caregiver's responses to my questions and see patterns that fit themes that related to my four research questions. Then I was able to look at patterns between the group of familial caregivers to see overarching

patterns that emerged from the data and make some conclusions for the study, which will be discussed in Chapter Four.

Issues of Trustworthiness

As explained by Cope (2014), qualitative research had often been criticized for not having the scientific rigor that its quantitative cohort possesses. Quantitative analysis is most often measured by experimental, objective measures, whereas qualitative research evaluates lived experiences, phenomenon, and theory/theories (Cope, 2014). Isaacs (2014) explained that qualitative research is more commonly being accepted as a public health necessity and often significantly contributes to the field. Although qualitative and quantitative research methods have different standards of rigor, qualitative research possessed a level measurability in which credibility, transferability, dependability, and confirmability were outlined as evaluative criteria for studies like this one (Cope, 2014).

Credibility

Credibility in qualitative research supposed that truth lies within the collected data of the participants' views, along with the researcher's interpretation and representation of them (Cope, 2014). Qualitative studies were further considered credible if the human experiences described were recognized by other individuals who shared these same experiences (Cope, 2014). For credibility purposes, I ethically interpreted and represented the views of the participants as it related to the phenomenon under study to the best of my ability. Member checking was offered to discern the credibility of my study. Creswell (2013) described this process as one in which the study's participants judge the accuracy and credibility of the findings and the way I interpreted them. This review was offered to

each of the eight study participants, but all participants declined to review their transcribed responses. It is important to note that study participants cannot be forced to complete member checking.

Transferability

Transferability as explained by Houghton et al. (2013) was determined when the original findings had the ability be transferred to other, similar results or situations while ensuring that the initial findings remained unchanged. In qualitative research, the standard of transferability relied on the desired outcome of the study (Cope, 2014). Thick descriptions were a measure undertaken during transferability, and it involved sufficiently describing the original findings of the research so that judgments can be made (Houghton et al., 2013). I provided the reader with detailed descriptions of the findings to ensure that the reader could make an informed judgment about the transferability of the findings, and whether the results were aligned with his or her own experiences (Cope, 2014; Houghton et al., 2013).

To ensure transferability in this study, I have openly described all study procedures and processes undertaken. This was expected to provide enough information so that, when reviewed by another researcher, said individual(s) would be able to trace each step taken and replicate the study undertaken for themselves (Houghton et al., 2013). I have inquired about the perceived experiences from the perspective of the familial caregivers of MAs who consumed alcohol. For this reason, and to ensure clarity, I developed flexible, probing questions to evoke prolonged engagement and depth of

responses from the study's participants (see Appendix B). This was done to ensure that the collected data is thick and transferable.

Dependability

Dependability was said to be related to the stability of the collected data (Houghton et al., 2013). Dependability was further shown when a study can be replicated with the use of similar participants in similar conditions (Koch, 2006). Studies that can be audited are also said to be dependable (Koch, 2006). In qualitative research, a well-maintained audit trail is vital (Cope, 2014). I have enhanced the dependability of my study by using an audit trail. This audit trail consists of interview transcripts, data analysis, and process notes to show how I arrived at the research findings.

Confirmability

Houghton et al. (2013) described confirmability as the accuracy of the collected data. In confirmability, it was essential for the researcher to be able to clearly show that the collected data represented the responses that were received from the participants and not the viewpoints of the researcher (Cope, 2014). Specific manners in which this can be done were by using direct quotes from the responses of the participants, or reflexivity by the researcher (Houghton et al., 2013). Reflexivity, as explained by Darawsheh (2014), involved continuous self-reflection by the researcher in which they exhibit awareness of their actions, feelings, and perceptions. Direct quotes, as suggested by Houghton et al. (2013), were inclusive of contextual accounts and examples of raw data from the study participants so that other interpretations could be reviewed. This not only improved the researcher's ability to be transparent as it related to their role in the research, but it also

allowed the researcher to incorporate the necessary measures to ensure credibility throughout their study (Darawsheh, 2014). To ensure confirmability throughout this study, I maintained a research journal.

Ethical Procedures

Before the start of the study, I obtained approval from Walden University's IRB (Approval No. 02-28-18-0272439). All participants were treated according to the ethical guidelines that have been established by Walden University's IRB. All participants were free to choose whether they would like to participate. Participants were aware that any questions which made them uncomfortable could be skipped without consequences. Additionally, participants were aware that they could withdraw their consent to participate at any time without penalty to either themselves or the MAs in the study to whom they are related. It was further explained to each participant the correct measures to take to withdraw their participation consent from the study.

There was no known harm associated with participating in this study. None of the participants experienced any harm associated with participating in this study, therefore, no referrals were made to local support services, although contact information for these services was included in the participant's consent form and was reviewed with the participant before beginning the study. Each participant completed a consent form and the participant's confidentiality was protected. Each interview took place in a private location and each participant was assigned a unique pseudonym participant identifier at the beginning of the study (Creswell, 2013). Files and transcripts have stored in a locked file cabinet in my home office, and I am the only individual with access to said files and

transcripts for a five-year period. After the 5-year period, the data will be destroyed via Gone for Good Document and E-Waste Solutions in Birmingham, Alabama.

Summary and Transition

Chapter 3 provided a detailed discussion of the methodologies that were used to understand how MAs who reside in assisted living use alcohol and what, if any, effects it has on their ability to successfully age in their assisted living environment. The chapter began with an introduction that explained the significance of this research study and provided the primary research questions. The qualitative research methodology of phenomenology that were used to examine this phenomenon were discussed as well as how the participants were selected, the role of the researcher, the ethical procedures that were taken to protect the study participants, and means of the data collection, analysis, and storage processes. In Chapter 4, the results of the study are discussed and analyzed.

Chapter 4: Results

Introduction

The purpose of this study was to provide resources to help ALC staff and familial caregivers address any alcohol abuse concerns of MAs living in an ALC. This chapter includes a discussion of the expert panel review, sampling logic for the research study, demographic profile of the study's participants, research questions, data collection and analysis methods, theme development, evidence of trustworthiness, and results.

Expert Panel Review

An expert panel was created to review and validate the research questions intended for this study. Wu and Lu (2014) explained that expert panels are used in qualitative research when the researcher is interested in clarifying the scope of their research along with ensuring that their research instrument measures the primary objectives of the study. Since my research focus dealt with a sensitive and protected population of individuals, I believed it best to seek the expertise of a specialized group of individuals who have both a trained and a working knowledge of the population under study. The expert panel consisted of a geriatric psychiatrist, a clinical social worker with a primary focus in the MA population, and an assisted living administrator. They noted that the questions were thorough and well-rounded. Reviewers felt that the wording of questions should yield adequate information to address the research concerns. They did not have any recommendations for changes. However, one panelist asked why here was no question about the amount of alcohol each MA consumed. I clarified that it would be

difficult for familial caregivers to address this question if they were not present during each time the MAs consumed alcohol.

Sampling Logic

During recruitment efforts, 13 candidates were encountered and pre-screened. Interested familial caregivers of MAs were required to meet the following criteria:

- Be a familial caregiver of a MA aged 65-85 years of age,
- Have a MA parent/relative residing in an assisted living community in the United States
- Not have a MA parent/relative diagnosed with a cognitive impairment or a diagnosis of Alzheimer's or other dementia-related diseases and/or be receiving medical treatment for Alzheimer's or other dementia-related diseases per self-report.

After prescreening, it was determined that eight were eligible for participation. Of these eight participants, it is important to note that four were recruited using the snowball sampling method. This method, as explained by Cohen and Arieli (2011) works well with those difficult to reach populations. This method directly addresses the potential participants mistrust towards the researcher as they are being brought to the researcher by someone that is already within their trusted network (Cohen & Arieli, 2011).

Two potential candidates were considered ineligible because they feared that their MAs would be retaliated against in some manner by their ALC because of their

participation despite being told that the ALC would have no manner of knowing that they participated. Two other potential participants were considered ineligible because they were not the caregivers of a living MA. Their loved ones were deceased, and they would not have been able to answer the questions related to the current behaviors of the MA. Finally, the last ineligible participant explained that the MA that he cared for was 94 years of age, therefore, outside of the set age parameters for this study.

The participants for this study were all females, who fulfilled the role of either a daughter or niece of an alcohol consuming MA residing in an ALC in the United States. Six of the participants provided responses related to the drinking habits of a mother/aunt, and two of the participants provided responses related to the drinking habits of their father. Each of the participants identified as Caucasian. Six noted that their MA resides in an ALC in the Southeastern portion of the United States, and one resides in an ALC in the Midwest.

For those familial caregivers who met the above-mentioned criteria, the IRB approved consent form was reviewed with them by the researcher and they each signed said consent form and received a copy for their records. There was one in-depth, semi structured, face-to-face or telephone interview conducted with each familial caregiver participant. The interviews were conducted at an agreed on quiet location that was convenient for me and the familial caregiver participant. Seven of the interviews took place via telephone and were conducted in the privacy of my home. The one face-to-face interview that was completed was conducted in my office after normal business hours. The interviews lasted 45-60 minutes, and study participants were given a $100 Visa gift

card incentive for participating in this research study. I recorded each participant interview with an audio recorder. Interviews were transcribed through a professional service, Tybee Types based in Savannah, Georgia. After reviewing the transcriptions, I hand-coded and analyzed the collected data.

This study included the following participants, who are identified by pseudonyms: Summer, Jenny, Gloria, Winter, Tiffany, Gwen, Sasha and Bella. This section will describe the familial role and responsibilities of each of the study's participants and the MAs to whom the familial caregiver is related in order to provide a better understanding of whether the MAs' alcohol use affects their ability to successfully age in their ALC based on the views and opinions of their familial caregivers.

Summer participated in the study on behalf of her father who moved into an ALC with his spouse after he contacted both her and her brother and explained that he could no longer care for his wife, their mother, who had been diagnosed with dementia. Summer and her brother assisted their parents with moving into an ALC nearby their son. Although both parents moved into the ALC, their father lives in a different section of the residence than his wife does, but he visits with his wife daily and provides care for her within the community. Summer further noted to the researcher that she is a married mother who works outside of the home in a Southern state and visits with her parents, when possible, at their ALC.

Sisters Jenny and Tiffany participated in the study on behalf of their mother who moved into an ALC in 2016 once their father became ill and could no longer care for himself. Their parents moved into the ALC together, but their father recently died,

leaving only their mother in the ALC currently. Jenny explained that she does not live near her mother's ALC, but her sister Tiffany does, who visits regularly. Jenny visits bi-monthly. Jenny reported that she is a divorced mom who is retired. Tiffany is a married mother who works in health care in a Southern state. The two sisters had different takes on their mother's drinking habits. Jenny stated that, "I don't bother her about her drinking unless we're somewhere and have to be in close quarters because she can't be drunk and prickly." She further noted that she does not really worry about her mother's drinking but does not want her to be injured by a fall. Tiffany reported on her mother's alcohol use in the ALC as a barrier to her appropriately participating in activities in the ALC, leaving her room for meals, and showing interest in simply moving around. However, Jenny noted that her mother has a unique medical condition, which has resulted in her being declared legally blind and, therefore, her alcohol use causes Jenny to worry.

Tiffany explained that her mother, who currently resides in her ALC with the assistance of a sitter, who stays with her three nights per week, has two serious medical conditions, one of which has left her with visual impairments. Tiffany shared that although their mother is considered legally blind, their mother independently pours on her alcoholic drinks in her apartment and does not leave her room under any circumstance unless she is going to a doctor's appointment. Tiffany reported visiting her mother at least once per week, but that she always visits on the weekends because of her work schedule. Jenny concurred with Tiffany that their mother poured on her own drinks and consumed alcohol only in her ALC apartment, so no one really knows how much alcohol she was consuming.

Gloria participated in the study on her mother's behalf and was one of the only respondents to note that either she or a member of her family spent time with her mother daily. Gloria reported being married with a child. She recently left her job, where she assisted other family with transitioning their loved ones to an ALC in order to spend more time with her own family. Gloria noted that her mother continues to be very active in her home community outside of the ALC, and, since she can still drive, she leaves her ALC daily to volunteer at local organizations in town. Gloria's mother has been a widow for 21 years and has begun to have some short-term memory issues, and this was the primary reason that they chose to place her in an ALC.

Winter participated in the study on behalf of her father, a retired physician. Winter is married with two sons and works full-time. Her father, who lived five hours away, recently moved in an ALC near her because she was the child who lived the closest to him at the time. Winter explained that her father has been a widow for 20 years, so he primarily moved into an ALC for companionship, assistance with his activities of daily living (ADLs), and meal assistance. Winter visited with her father in and outside of the ALC three to five times per week. She further noted that she had a good relationship with the staff who works at the ALC, and they gave her updates during her visits.

Gwen participated in the study on behalf of her aunt, whom she was related to by marriage. She had assumed primary caregiving responsibilities for her aunt because she was the only female relative nearby. Gwen has been married for nearly 30 years and the mother of two adult children. She retired from work as a social worker as a result of a disability. Gwen's previous work experience has assisted her greatly in her caregiving

responsibilities. Gwen's aunt moved in an ALC after she had a minor stroke, and the family noted that she was having some short-term memory issues. Gwen's aunt is a widow, but she did report that she does have a boyfriend who lives in the ALC community with her, but that they do not share an apartment. Her boyfriend reportedly had assumed the responsibility of assisting her aunt with many of her ADLs in the ALC. Gwen reported visiting with her aunt both in and outside of the ALC two to three times per week with one of these visits always occurring on a weekend day.

Sasha participated in the study on behalf of her mother who resides in an ALC in the Midwest, near Sasha's brother. Sasha is married with children and works in a school setting in a Southern state. Sasha's mother moved into an ALC as a proactive measure because her mother's home was too large for her to maintain after her father died. At the time, Sasha's mother was not living near any of her family. Sasha explained she and her mother have never really been extremely close because her mother has always been a "glass half-empty" type person and would prefer to be to herself than to intermingle with others. Sasha and her family visit with her mother at least one weekend per year because of the distance, but that she speaks with her via telephone almost daily. She can report on her mother's consumption patterns based on reports that she received from her brother who is the one who purchases alcohol for their mother and delivers it to her at the ALC.

Lastly, Bella participated in the study on behalf of her mother. Bella is newly married with a daughter. She is currently unemployed. Bella has two siblings but was elected to be the primary caregiver for their mother since she was unemployed. Bella did not disclose how long her mother has resided in her ALC, but she did note that that

moved her into an ALC because her mother lived in a large home with stairs and a large yard and she unable to maintain it all, plus she needed the companionship. Bella visited with her mother daily, even on the weekends, and she reported that her mother spends a "decent amount" of time outside of her ALC as well. Bella's mother is dependent on these daily visits. Bella discussed that if she falls ill, has a change of plans, or cannot visit with her mother on a given day that her mom will become anxious and calls several times to inquire where she is. Bella has noted that this anxiety and the repeated phone calls have nothing to do with her mother's memory, but instead in her opinion seems as if her mother has become co-dependent and expects her to visit daily. Bella did mention during her interview that she has begun to structure each of her days to ensure that at some point during the day, she is able to have a face-to-face visit with her mother. Finally, Bella was able to give reports on her mom's drinking patterns both in and outside of the ALC because she buys much of the alcohol that her mother consumes and spends a significant amount of time around her when she is drinking.

Research Questions

The goal of this qualitative, phenomenological study was to determine whether consuming alcohol in an ALC affected MA's ability to successfully age per the opinion of their familial caregiver. Familial caregivers, for the purpose of this research study, are defined as any individual who shares a relationship with and provides care for the MAs for which they are reporting on, whether genetically or by marriage. The results from this study will identify whether the drinking habits of MAs in ALCs affects their overall ability to successfully age in their community. Successful aging can be defined in various

ways, depending on the context in which it is being presented. For this study, successful aging included how the familial caregiver viewed his/her MAs' aging process. Other factors closely associated with successful aging include longevity, life satisfaction, freedom from disability, independence, mastery and growth, and active engagement with life (Martin et al., 2015, p. 15). The results are also expected to provide ALC administrations, policy makers, MAs, familial caregivers of MAs, and medical professionals with the necessary information to support the argument that public health policies should be created. Such public health policies could better ensure that MAs in ALCs can handle their life transitions appropriately as to prevent an adverse effect on their overall health development. Such public health policies related to recommended amounts of alcohol consumption at ALCs could result in positive changes to improve the lives and the life expectancy of MA's who reside in these facilities. The study questions that guided this research are described below along with short explanations.

RQ1: To what extent do daily experiences in assisted living communities result in alcohol use by MAs, as perceived by their familial caregiver?

RQ2: Do loneliness or social isolation, as perceived by the familial caregiver, affect the ability of the MAs to age successfully in place in the assisted living community?

RQ3: What emotional, physical and social challenges do familial caregivers perceive their MAs parent/relative face by consuming alcohol in the assisted living community?

RQ4: How do the familial caregivers of MAs describe the alcohol consumption of their MAs parent/relative in the assisted living community?

Data Collection

Thirteen individuals were prescreened for this study. Of the thirteen, eight were determined to be appropriate and were subsequently consented and interviewed. Identifying appropriate participants for this study was a daunting task. It took 16 months and four requests for procedural changes via Walden's Institutional Review Board (IRB) to find eight suitable candidates to interview. Along the way, the recruitment area for the study was expanded to include the entire United States. The age criteria of the MAs residing in an ALC for inclusion in the study was changed from 65-75, which were originally referred to as young-old adults, to 65-85, which is inclusive of MAs. The participation incentive was modified from a choice of a $15 gift card to either Target or Wal-Mart, to a $100 Visa gift card. Finally, recruitment assistance of Walden's Participant Pool as well as the Public Relations Department of AL-ANON Family Groups was requested.

Additionally, I remained neutral throughout each interview, with an awareness of tonal inflections for those interviews that took place via telephone. I did not provide the participants with positive or negative feedback during the interviews, kept all personal thoughts and opinions to myself and conducted reflective journaling following each interview to further elaborate on areas which stood out.

Data Analysis

Initially, I proposed the use of the Computer Assisted Qualitative Data Analysis Software (CAQDAS), NVivio11. The use of CAQDAS was proposed as an effort to lessen the burden of analyzing the collected data. Once the data for this study was collected, transcribed, and reviewed, since there were only eight study participants, I determined that the best method of analyzing the collected research data was do so manually. I made four copies of each interview and began the hand coding process by categorizing all the responses that held similar meanings as compared to the overall research questions that have been developed. I used different colored highlighters in order to group together those responses that were related to one another, and so that they would be easily identifiable. As discussed by Stuckey (2015), the creation of storylines based on collected data, it was my intent to create a storyline from the transcribed responses of the study participants.

Once the analyzed data was coded, I was able to determine what the emerging themes were, and it was determined that there are three overall themes for my collected data which were, changes associated with alcohol consumption, overall health concerns and social interactions as a source of alcohol at the ALC. The quality of the data collected from familial caregivers who were open about their own experiences, led to this study achieving saturation. Additional interviews may have caused additional themes to emerge, but with the collected data, there is enough information available to replicate this study.

Evidence of Trustworthiness

Credibility

The credibility of this study relied heavily on my ability to correctly interpret and represent the views of the participants as it relates to the phenomenon under study. Connelly (2016) suggests that the credibility of the study and its findings is one of the most important criterions of trustworthiness. There are various manners in which one could ensure the credibility of a qualitative study, but the two most common methods are member checking and triangulation (Connelly, 2016). For this study, member checking was originally proposed to discern the study's credibility. It was expected that member checking would be conducted by providing each participant with a rough draft of the developed themes of the study to obtain their views about the direction in which the analysis is going along with determining what, if anything, is missing as it relates to their transcribed responses. This review was offered to each of the eight study participants, but all participants declined to review their transcribed responses. It is important to note that study participants cannot be forced to complete member checking.

With triangulation in mind, Carter et. al. (2014) explained that method triangulation is often used in qualitative studies and employs the use of various methods of data collection related to the same phenomenon. To ensure that my study was credible, I used method triangulation and compared the collected data on both an individual and group basis. This simply means that everyone's collected responses were compared against the overall research questions for my study along with being closely compared to the responses of the other participants to help identify themes and/or similarities in

responses. Along with this comparison, I also took field notes and conducted observation during each of my interviews in order to collect additional, unspoken information from my participants.

Transferability

With transferability in mind, it is my goal to confirm that I have provided a vivid picture of the collected data in order to inform my reader while ensuring that I have noted that the story that I am telling is not everyone's story (Connelly, 2016). This study provides new information as it relates to familial caregivers' perspectives of alcohol use by their MAs in their ALC. The findings can contribute to future knowledge and are quite possibly transferrable. This study also highlights the need for more research to be conducted on MAs residing in ALCs who consume alcohol.

Dependability

Connelly (2016) describes dependability as the overall stability of the collected data over time and the climate of the study. One such way dependability can be addressed is using an audit trail, which was done in this study. Each participant consented to have their study responses audio recorded for accuracy and to enhance the dependability of the study. This audit trail further consisted of interview transcripts, study-related notes taken by the researcher during each interview, and data analysis including coding notes to show how I arrived at the research findings.

Confirmability

In confirmability, it is essential for the researcher to be able to clearly show that the collected data is representative of the responses that were received from the

participants and not the viewpoints of the researcher (Cope, 2014). Direct quotes, as suggested by Houghton et al. (2013), are inclusive of contextual accounts and examples of raw data from the study participants so that other interpretations can be reviewed. In confirmability, the researcher also seeks to show that their findings are consistent and be replicated (Connelly, 2016). To ensure confirmability throughout this study, I had each of the participants interviews transcribed verbatim by a transcription service.

Themes

Themes Related to Research Question 1**:** To what extent do daily experiences in assisted living communities result in alcohol use by MAs, as perceived by their familial caregiver?

Responses to this research question provided me with an array of familial caregiver concerns and insight into their MA's drinking habits both in their ALC and prior to their move-in. Themes related to RQ1 included changes with consuming alcohol, overall health concerns, and social interactions at the ALC.

Parent Theme 1: Changes associated with alcohol consumption

When asked whether or not the familial caregivers have noted changes related to the alcohol consumptions habits of their MAs, seven of the eight respondents stated with certainty that their MA has been drinking as long as they can remember, with only one respondent noting that her loved one did not drink daily and mainly only had a glass of wine when she drank on a special occasion. Tiffany and Jenny, who are sisters, but who gave their own perspectives on their mother's drinking behaviors, had one of the more unique stories. What made their story unique was the notion that their mother, who both

agreed was legally blind, poured her own alcoholic beverages daily, and both sisters noted that they have limited knowledge as to how much she consumed on a daily basis because she has a sitter who goes out into the community to purchase her alcohol for her. Tiffany and Jenny individually noted that they have not reviewed receipts for alcohol purchases, which should list what type(s) of alcohol was purchased and how much alcohol was purchased. However, Tiffany has noticed debit purchases for alcohol on her mother's account but revealed that she has never calculated to see what specifically was purchased and how much was spent on these purchases. Tiffany and Jenny both reported that they could not clarify whether their mother drinks because she has experienced loneliness because of the death of her spouse or that she is simply drinking out of habit since she has done so for majority of her adult life. Jenny discussed during her interview that her mother has been drinking since she was 34 years old and prior to moving into her ALC, her mother drank for the following reason:

> We lived in [hometown]and Mother and Daddy moved back because of Daddy's work. Mother was 34 and Daddy was 36 and they had friends, professional friends, [and] friends who had a standing in the community. It wasn't skid row friends. They all went to ballgames; they went on vacations together; they hung out all the time. We spent Thanksgiving with them, and they were heavy drinkers, and my mother enjoyed that. They partied. They partied hard and my Daddy didn't drink… He was a moderate drinker, but Mother got in with their crowd and it was like we're still the children.

Tiffany and Jenny both explained that they thought moving their mother into an ALC would lessen the amount of alcohol that she consumed, but the move has not impacted their mother's drinking habits.

Another participant, Winter, stated with certainty that her father's drinking habits have decreased significantly since he moved into an ALC mainly because he now has people to socialize with daily. His wife died more than 20 years ago, and, after her death, he lived alone in his home until moving in the ALC a few years ago. Immediately following his wife's death, Winter noticed that he "overindulged" often and would rather drink than eat, which caused her to become worried. Although his alcohol use had never had a negative impact on their family structure, the family has always been aware of his daily drinking habits. Winter did not report in numbers how much her father once consumed but did state that:

> It is less than it used to be. It used to affect his ability to, I don't know, just, like, decide to eat meals or – you know what I mean? A little bit more on the personal side, like, "Oh, I'm fine," and so then, if he doesn't eat dinner, we know he's not fine the next day. He needs to continue to eat his meals. And his alcohol intake has decreased so much since he's lived at [an ALC]. We're very pleased. We were a little concerned that maybe he would be lonely in a room, but because he's out of his room so much, he doesn't need the alcohol as much, we don't feel. So, we've been pleasantly surprised.

Therefore, it appears that issues of loneliness can impact MAs' drinking habits, in many instances, causes them to drink more. Planning activities to ease isolation may have a

positive impact on their overall alcohol consumption habits, thusly allowing them to successfully age in their current setting.

Parent Theme 2: Overall health concerns

The eight familial caregivers all reported varying degrees of overall health concerns ranging from minor strokes, to eating concerns, recent falls (both related and unrelated to alcohol use), and short-term memory issues associated with growing older. However, there were no reports that would suggest that there was an increase in the MAs' health-related concerns based on the responses of the familial caregivers.

Sasha's interview revealed that she believed her mother struggled with her psychological issues daily since residing in her ALC. Sasha said her mother arrived at a point where she would rather drink than to eat appropriately. Sasha stated:

> She's always, since I've known her, had issues with food either not tasting well to her or it's not good or she doesn't want to eat it. From a therapist's perspective, I definitely think she has an eating disorder and has for years. She takes, and still does, laxatives at different times. Last time I was there – I've never heard of this one before – but she had some Brandy in her kitchen cabinet, and she says she takes that when she gets diarrhea.

Sasha explained that her mother has been known to isolate herself when eating and not eat in front of others. Since moving into her ALC six years ago, she has lost 70 pounds, and it is believed that she only consumes between 500-600 calories per day. Sasha did report that her mother will periodically go the "after hours" grill and pick up a sandwich, but she mainly eats in her apartment because her son buys her groceries and brings them

in for her. Also, Sasha reported that her mother periodically takes laxatives, which correlates with her belief that her mother has an eating disorder, although she has never been formally diagnosed with one. Although ALCs monitored weight loss among their residents and brought it to the attention of the family, until a resident moved into a more specialized portion of the facility, there had not be any real intervention.

Another major health concern for the MA population is falls, as they can result in fractures and mobility issues. Bella, who appeared to be the most worried about her mother's overall health as it related to her drinking habits, noted several instances in which her mother fell, which recently resulted in a broken arm where she needed to have a plate and screws. Bella believed that these falls were directly related to her mother's drinking habits. Bella also noted that her mother's drinking habits have remained steady over the years, as her mother had always been a drinker, but, as she continued to age and become affected by other medical co-morbidities, including fall-related injuries, she had become more unsteady and more injury-prone both in and outside her ALC.

Parent Theme Three: Social Interactions as a Source of Alcohol at the ALC

Many ALCs advertise the activities available to residents when people shop for the right place for their loved one to reside. ALCs offer a wide range of activities including exercise classes, live music events, weekly bible study, and socializing games including but are limited to bingo, dominos and trivia. In addition to these activities, most ALCs offer happy hours to residents where the residents are provided alcoholic beverages. Of the eight study participants, three participants of this study reported that their MAs' participated in the happy hour festivities offered at their ALCs. All eight

participants reported that their parent's ALC had happy hours and alcohol was also provided when they attend special events such as birthday celebrations, holiday related gatherings, or sporting events.

From the perspective of social interactions, the responses of the study participants were divided. Four of the respondents reported that their loved ones rarely or never participated in any of the offerings at their ALC outside of the meals that they were offered. The four other respondents noted that their loved ones were highly social and loved being part of the many activities that are offered at their community. Of the four who reported that their loved ones often participated in in the social offering in their ALC, all noted that although they participate in activities that are not alcohol related, they also participate in those activities which involving socializing while consuming alcohol.

Summer's father, who lives in the ALC portion of the continuing care retirement community, walked over daily to the specialty care unit at his assisted living to provide care for his wife. Summer noted that this affects his ability to socialize in the ALC because he left his apartment each evening at 5:30 PM, walked over to her mother's building to ensure she ate dinner, spent the night with her, woke her up the following morning, dressed her, made sure she has breakfast, and then walked back to his apartment to start his day. Since he was with his wife from dinner through breakfast and only on his own during the day, Summer reported that he mainly drank during dinner time, prior to going to her mother's apartment. These drinks were consumed both in and outside the ALC, particularly when he ventured outside of the ALC to a local restaurant. She noted that her father did not participate in happy hour in the ALC but participated in other

social events in the ALC in which alcohol was served and normally consumed a few beers.

While many ALCs offer happy hours, most ALCs described in this study also allow residents to keep and consume alcohol in their own apartments. Five participants of the study specifically noted that their MAs preferred to drink in the privacy of their apartment. Participants were asked if they believed their loved one consumed alcohol in private, so they were not judged by others, each respondent gave a resounding, "yes." With the reports of the research participants in mind, it can be surmised that their MAs tendency to drink in private may have a degree of loneliness present, but it could also be related to shame and the stigma that surrounded alcohol consumption.

Additionally, since residents were permitted to leave the ALC, either on their own if they can provide transportation or when someone takes them off-site, many ALC MAs can drink outside of the ALC. For example, many residents get taken out to dinner where they are free to order drinks from a bar or at a restaurant. All eight of my respondents were able to describe experiences in which they have taken their MAs out for a meal or a family event and alcohol had been consumed. Each reported that when their MAs consumed alcohol outside of the ALC, they were passengers and not driving. Seven of the participants did not identify a time where their MAs may have over-indulged, but Bella claimed that her mother does not always know her limits and there have been times both at her ALC and while at dinner with family that her mother had over-indulged. An example provided by Bella was that she has friends who own a winery, and her mother enjoys visiting the winery, but that they only go "every now and then" to monitor her

mother's intake, and her mother never drives to or from the winery. Gloria, whose mother reportedly drives "a lot," did not mention any instances in which her mother has consumed alcohol and gotten behind the wheel.

Themes Related to Research Question 2: Do loneliness or social isolation, as perceived by the familial caregiver, affect the ability of the MAs to age successfully in place in the assisted living community?

The eight participants gave varying responses as it related to their perception of the loneliness experienced by the MAs in the ALC. Some respondents mentioned their concern over the possibility of their MAs suffering from depression. A few of the respondents could not adequately verify whether their loved one's loneliness had been with them long-term or has developed since moving into their ALC. Some respondents reported that their MAs were introverted and not active in their social lives before moving into their ALCs. Others reported that their MAs appeared lonelier since either the death of their spouse or since moving into their ALC.

Parent Theme 1: Changes Associated with Alcohol Consumption

It was determined during the data collection and analysis stage that none of the respondents reported that their loved ones began drinking after moving into their ALC. I discussed with the respondents about any emotional, social, mental, or social challenges faced by their MAs while consuming alcohol in their ALC. All participants reported that their MAs had been drinking much of their adult lives and that many had an increase in their drinking habits after the loss of a spouse or child and/or prior to moving into their

ALC. This increase could potentially be linked to changes in their mental or emotional state. Although there were no reports of increases in drinking habits after moving into the ALC, there were reports that several of MAs would drink in social settings in their ALCs, such as during dinner or during the happy hour offered by the facility. While Jenny, Sasha, and Tiffany all agreed that their mothers refused to drink in public settings or even outside of their apartment in the ALC, Bella, Gwen, Summer and Winter all noted that their MAs loved the social interaction that comes along with drinking among friends in a social setting in the ALC and with family during events outside their ALC. Gloria explained that while her mother will drink in social settings, she was very cautious as to how much she consumed and who she was around while she drank. Gloria specifically stated that her mom "is not a heavy, heavy drinker. She'll have a glass of wine with us if we're out to dinner or something. She doesn't drink every day, and she doesn't like to drink a lot because alcoholism does run in her family, so she's very conscientious about that." Bella explained that her mother was "from the old school" and did not want her Sunday school class or church family to know that she drank.

Gwen reported that her aunt's ALC only has Happy Hour on Thursday and that they play music during Happy Hour, which her aunt loved, and she would sit out amongst her peers with her wine or cocktail and enjoy the music. Gwen further noted that her aunt was "all about the appearance" and would not drink beer or have more than one glass of alcohol amongst her peers. Gwen stated that her aunt has specifically asked at times, "Is this okay? Are you sure that this is all right that I have something? Are you sure it's all right if we have a glass of wine?" Summer's father, on the other hand, would have a few

beers amongst his peers during Happy Hour or other social activities in the ALC, but Summer believed he seemed to know his limits and did not over-indulge.

Parent Theme Two: Overall Health Concerns

As earlier noted, none of the respondents described health concerns for their loved ones that were related to their MAs' drinking habits. There were comments made that one could discern as it related to certain conditions faced by the MAs and the likelihood that it was related to their loved one's drinking habits. Sasha expressed that her mother was healthy, "for the most part, physically healthy." Sasha believed her mother "struggles" emotionally. She also noted her mother's poor consumption of enough calories to make it through the day. She claimed that her mother consumed between 500-600 calories per day of actual food, all of which is done so in her room. She noted that not only does her mother refuse to eat meals in the dining area at the ALC, but she does not like to go out to have meals in public with her family. As a result, she isolated herself in her own ALC apartment much of the day. Her only reported activity was watching true crimes shows and national news channels each day.

Summer, on the other hand, explained that her father was "in really good condition and has all of his mental faculties. He has problems with his joints; they ache a lot, really bad knees, so he uses a cane to help him, but for the most part, he's in really good physical condition." Jenny had a similar outlook as Summer as it relates to her mother's overall health. She discussed that her mother, for her age, is in "pretty good" health. Jenny elaborated by noting that her mom did not move around a lot, mainly

because of her vision issues, ate all meals in her room, and only left her room to attend beauty or doctor appointments.

Bella explained that her mother's health "has declined in the past several years, especially since she broke her arm" and is often in a lot of pain. Bella further explained that this increased pain has not kept her mother from consuming alcohol, and she was certain that "she had had some drinks" when she fell and broke her arm. Finally, Bella discussed that her mother's drinking "always affects her emotionally," causing her mother to begin to cry and express that she was depressed.

Gwen was one of two participants that mentioned minor memory concerns as it relates to her MAs' overall health. She noted that prior to moving into the ALC, her aunt became lost a couple of times driving and couldn't figure out how to get home. In her ALC, this has been less of an issue as she has a "companion" that she can lean on to keep her on task and aware of her surroundings. Gloria, who also mentioned that her mom is having some "short-term memory issues," contended that it has not affected her mother's independence much, but she must be reminded to take her daily medications for her high blood pressure.

Winter's perspective of her father's overall health was that he was doing "amazingly good" and had little to no issue with any of his diagnosed medical conditions. She further explained that "he is becoming more comfortable staying in, whereas he used to be stimulated by the getting out," which she felt had further contributed to his good health outcomes. Finally, Tiffany, believed her mother was physically "pretty strong."

She explained that her mother was affected by orthopedic issues, “arthritis in her knees and hands and ankles, so mobility is probably her worst problem.”

While minor aches and “senior moments” of temporary memory issues are not surprising in the daily life of most MAs, this study’s biggest overall health concerned appeared when Sasha reported that her mother drank daily and consumed at least 3.785 liters of gin per week in the privacy of her apartment. According to the NIAAA (2016), healthy MAs, meaning they take no daily medications, should not consume more than three drinks per day or seven alcoholic beverages per week. As reported by Sasha, her mother does take medications daily, although she did not identify what they were or the related diagnosis. As discussed by Seddon et al. (2019) the consumption of small amounts of alcohol by MAs can be problematic as their bodies metabolize and excrete the consumed alcohol slower. Furthermore, consuming alcohol, along with medications can cause adverse reactions to include but are not limited to a reduction in the efficacy of the medication, elevated blood alcohol levels, and the worsening of medication side effects (Seddon et al., 2019, p. 1).

In addition to the amount of alcohol Sasha’s mother consumes and her significant weight loss from the low number of calories from food consumed, she may also be experiencing issues of depression. From a perspective of intermingling with others, her closest relationships in the ALC are with the hairstylist and one of the dining hall workers. Sasha believed that her mother isolated herself in her apartment and did not socialize with others who live there because each time she became close to someone, that person died. Sasha noted during her interview that her mother lost her young child

(Sasha's sibling) in a tragic accident many years ago and felt that this is when her mother began to drink, based on a report from her father before his passing. Although her mother often reflected on her memories of this child, Sasha could not recall whether she ever attended therapy or sought out grief counseling after this loss. Sasha's mother has become increasingly isolated and grief may well have played a part in her use on alcohol. Based on feedback from Sasha, it appears that her mother is a frequent binge drinker.

Themes Related to Research Question 3: What emotional, physical and social challenges do familial caregivers perceive their MAs parent/relative face by consuming alcohol in the assisted living community?

The challenges related to the MA's alcohol consumption in their ALC as perceived by their familial caregiver were emotional, social, and physically related. At least two of the respondents noted that moving their loved one into an ALC was a positive, life-changing experience for them. They were dealing with MAs who were isolating themselves in their homes and not socializing with the outside world. After transitioning into their ALC, most participants noted that their MAs had become more active and had formed small groups of friends with whom they were able to share meals and participate in daily activities. However, a few respondents noted that their loved ones were more socially isolated at the ALC. The themes that will be discussed include changes with consuming alcohol, overall health concerns, and social interactions in the ALC.

Parent Theme One: Changes associated with Alcohol Consumption.

Changes associated with alcohol consumption in the ALC have been most prevalent with Bella's mother who has had at least two alcohol-related falls in the past year. The most recent of these falls resulted in an extensive surgery to repair her broken arm. Bella also noted that she believed her mother drank more when she became depressed. Bella explained that, when her mother consumed alcohol, she often began to cry and oftentimes became irrational. Bella recounted that, prior to moving into the ALC, her mother's drinking became worse when she would argue with her husband. After moving into the ALC, her mother's method of socialization often occurred while she sat on her individual porch outside her residence and had drinks with other nearby residents on their perspective porches. Bella stated her mother's neighbor, whom her mother described as "ornery," often made her mother upset and then she argued with this neighbor, and, as a result, her mother consumed more alcohol. So, while Bella's mother's ALC was not sponsoring a happy hour per se, the residents were facilitating their own socialization happy hour, which may not be beneficial to these residents successfully aging in place due to their alcohol consumptions.

Winter's responses as it related to changes with her father's alcohol consumption identified that he had had an overall decrease in the amount that he consumed since moving in his ALC. She explained that she felt that her father drank "out of a habit, and that is part of his day." Prior to moving into his ALC, Winter noted that her father's drinking:

> It used to affect his ability to, I don't know, just, like, decide to eat meals or -- you know what I mean? A little bit more on the personal side, like, "Oh, I'm fine," and

> so then, if he doesn't eat dinner, we know he's not fine the next day. He needs to continue to eat his meals. And his alcohol intake has decreased so much since he's lived at [ALC]. We're very pleased. We were a little concerned that maybe he would be lonely in a room, but because he's out of his room so much, he doesn't need the alcohol as much, we don't feel. So, we've been pleasantly surprised.

Parent Theme Two: Overall Health Concerns

None of the eight respondents identified heath issues directly related to consuming alcohol in the ALC, but all were able to identify general health concerns that their MAs face. Gwen explained that her MA had a stroke prior to moving into her ALC, and, although she does not have any noticeable physical defects as a result, she did have some pretty significant memory loss. When asked if she consumed more or less alcohol because of these memory-related issues, Gwen explained that her mother was a moderate drinker who knew her limits, so she did not overindulge, therefore, she stayed within or under the recommended HHS (2016) guidelines for alcohol consumption.

Gloria's perspective on whether her mother's alcohol consumption changed after arriving at the ALC as her mother suffered from an inability to taste. This occurred ten years prior when she received an injection of BONIVA for her osteoporosis. Gloria and I spoke extensively about her mother's inability to taste and how this affected her drinking behaviors. She noted that although her mother does not have an affinity for food, she does like to have her sweet wines. Gloria explained that her mother can taste the sugars in wines that are sweet, and, oftentimes, she will choose to drink, rather than eat, but she has never witnessed her over-indulge.

Parent Theme Three: Social Interactions as a source of alcohol at the ALC

As previously noted, social interactions varied in the responses from the respondents. Tiffany, whose mother has a live-in companion three nights per week, explained that her mother does not leave her apartment for any reason other than to attend medical appointments. When her mother moved into the ALC, she was accompanied by her husband, who suffered from numerous, chronic medical conditions, which limited his ability to move around outside of their apartment. They hired a caregiver and signed up for a meal delivery service so that their parents did not have to leave their apartment. Once her husband passed away, the family kept all the resources that were in-place for the couple for their mother.

Tiffany discussed that recently, the ALC has decided "that they were going to start charging $5 a meal to have it delivered, so that has given me ammunition that she was going to need to start going to the dining room again." Tiffany believed the current set up has further contributed to her mother's disinterest in being around others. Additionally, her mother's hearing has diminished, and Tiffany noted that her mother was too embarrassed to wear hearing aids, thus further isolating her mother from social situations at the ALC. Tiffany explained that her mother "feels like she misses some things with people talking to her or that are going on around her because she can't hear." Tiffany recounted growing up with a very outgoing mother who was always the life of the party and who had a great group of friends. She explained that her mother's life "became different" when all the children left home.

Tiffany noted that her mother was a librarian, and that she and her siblings lived a very comfortable lifestyle. Tiffany's mother defied the stereotypical reputations of librarians. In fact, Tiffany was known for having the "partying parents." Despite her mother being very outgoing prior to moving into the ALC, she refused to socialize with others in the ALC even when the staff personally comes to her room to retrieve her.

Themes Related to Research Question 4: How do the familial caregivers of MAs describe the alcohol consumption of their MA parent/relative in the assisted living community?

With research question number four in mind, the researcher is asking the respondents if they can accurately describe their MAs' alcohol consumption. The themes discussed are changes with consuming alcohol, overall health concerns, and social interactions at the ALC. The eight respondents were not able to completely identify alcohol exposure with their MAs in the ALC, but several noted that they used financial records to see how often their MAs was spending money on alcohol-related purchases. The most interesting responses to this question came from Tiffany, Sasha, and Jenny. Based on the information that they obtained by monitoring their individual MAs' expenditures and via interviews, loved ones' responses showed that their MAs often consume more alcohol than the FDA recommended drinking amounts. Sisters Tiffany and Jenny, whose mother has been declared legally blind, reported that their mother pours her own drinks. Sasha's mother, drinks at least 3.785 liters of gin per week, and these drinking patterns, per Sasha, are likely the cause for concern as it relates to her mother stomach's issues, lack of appetite, and refusal to participate in ALC activities.

Tiffany and Jenny, who gave varying responses describing their mother's drinking habits, both agreed that they were certain that she was drinking more than the one glass of wine per night that she reported as she recently asked them to stop bringing in her alcohol and only sends her sitter out to purchase it for her. A 750 ml bottle of wine, which according to the HHS (2016) is considered a regular wine bottle, contains approximately five glasses of wine. The sisters shared that they brought their mother one bottle of wine per week, so they were better able to monitor how much she is consuming. They tried to follow her consumption habits based on financial records, but they were of the belief that their mother was giving the sitter cash to make her alcohol purchases beyond the one bottle of wine per week the sisters had approved.

Sasha, on the other hand, explicitly noted that she does not purchase her mother's alcohol, but her brother does; he reports that he buys a minimum of a gallon of gin per week. Her mother reports that she only has three drinks per day and that she mixes them with soda. Based on the amount of alcohol purchased and assumed consumed per week, her mom would still be binge drinking.

Parent Theme One: Changes associated with Alcohol Consumption

It was difficult for all the caregiver respondents to determine the actual amount of alcohol consumed by their MAs as the respondents are not with their MAs all the time and their visiting patterns change. Two out of eight respondents admitted to only seeing their loved one, in person, once to twice per year. Their reports on their MAs' alcohol consumption were based mainly on financial records and behavioral patterns of their

loved one when they speak to them over the phone (i.e. slurred speech, volatile language patterns, etc.).

Sasha explained that even when she visits with her mother, during her once per year visit, she never saw her drink. She noted that her mother will express that she is ready for her to go, or stated, "I'm done for the day." Sasha interpreted this as her mother is ready to drink. She also admitted that she did not speak to her mother over the phone after a certain time of the evening as she had noted that it pained her to hear her mother slurring her speech.

Winter's perspective on her father's drinking was based on no prior knowledge of what he drank before he moved to the ALC because she did not see him regularly. Now that he lived nearby and they saw each other regularly, she noted his consumption habits were:

> Better than they used to be. He could talk himself out of, say, "Oh, I need dinner," or, "Oh, I need to make sure I've cleaned up the house," when he was living alone much worse than what he's done in an environment where he's cared for. Now, it's just more like part of his diet. I don't know how to describe it any other way than that. It's just a liquid meal. It's not affecting his judgment nearly as much as it used to because the consumption's down because he's got a better environment.

Parent Theme Two: Overall Health Concerns

Summer recounted an experience relating to the drinking habits of her MA. Summer explained that her father did not have a habit of consuming more than a few beers, and he mainly only consumed alcohol during social events. However, he had

recently taken a liking to Blue Moon beer and Buffalo wings. Her father, who still drives, often went out to have Buffalo wings and Blue Moon, and, during a recent outing, he fell from the curb, face-down, and injured his wrist. Summer did not believe that her father was intoxicated, but her father was not paying close attention to his surroundings. In his ALC, Summer believed her father only consumed alcohol with other residents, and he did not consume any alcohol alone in his apartment.

Winter, on the other hand, noted that her father drank "a little bit every day, but since he has been in the ALC, he's never had one of those instances where he overindulges." Winter claimed that when her father lived five hours away from her and she rarely saw him, she worried that he was choosing alcohol over food and that he was drinking more because he lived alone. Now that he is in an environment where the meals were prepared for him, he was eating regularly. He shared with Winter that he goes to the dining room for every meal, and he "feels like he lives in a hotel" because of all the meal options. Aside from better eating habits, Winter also noted that her father spent most of the day out of his room attending exercise classes, being social with his neighbors, and listening to live music whenever the facility offers it.

Parent Theme Three: Social interactions as a source of alcohol at the ALC

Jenny made a statement as it related to the amount of alcohol being consumed by her MAs. She expressed that she thought that her mother's inability to socialize in her ALC has made her drink more. To elaborate, Jenny noted that because her mother never left her apartment, she sat there and drank throughout the day. Jenny reported that her mother "becomes quite stern and says that she has worked with the public all her life and

now that she is retired, she is going to do what she wants to do." Although she and her sister have different methods by which they interact with their mother, they both reached the same conclusion as it relates to their MAs' drinking patterns: their mother was not being honest with them as it related to the amount of alcohol that she consumed on a daily basis.

Summary and Transition

This phenomenological study examined the drinking habits, as reported by family caregivers of MAs in ALCs to determine alcohol consumption impacts one's ability to successfully age in place. The study consisted on one face-to-face interview and seven telephone interviews with eight individuals who were pre-screened and identified as the familial caregiver of a MA. The study included eight females of whom seven were the daughters and one was the niece by marriage of a MA who consumed alcohol and resided in an ALC.

The findings for this study have been analyzed in this chapter, along with the sampling logic, research questions, data collection methods, data analysis procedures, evidence of trustworthiness and the themes that emerged. I have provided excerpts from the interviews that were conducted in order to provide data on the particular MAs, and familial caregivers of MAs, as it related to the alcohol consumption patterns, overall health concerns and likelihood of social isolation in ALCs in an effort to better identify what this population of individuals face when residing in an ALC, and how these behaviors may affect their ability to successfully age in place. The data that was presented in this study as it related to the perspectives of the familial caregivers suggests

that current amounts of alcohol consumption directly by MAs impacted their ability to successfully age in place in their ALC. Additional research among this population is needed to determine how to best control their alcohol consumption amounts, particularly in their ALC

In Chapter 5, I present my interpretation of the findings, the limitations of the study, implications for social change, and recommendations for future research and policy implementation.

Chapter 5: Discussion, Conclusions and Recommendations

Introduction

The purpose of this study was to understand the alcohol use of MAs in ALCs, and whether this alcohol use affected their ability to successfully age in their ALC, based on the views and opinions of familial caregivers. This phenomenological study built on Gaugler and Kane's research (2007), in which they determined that family members often visit their loved ones in ALCs and provide some degree of assistance to them. By using the phenomenological approach, I was able to gather in-depth details about MAs alcohol use, both in and outside their ALC, based on the perspectives of their familial caregivers. Prior researchers have studied communal alcohol use by MAs, but in a careful review of the literature, I noted that none of these studies specifically addressed familial caregiver concerns about alcohol use in ALCs (see Zanjani et al., 2013; Sacco et al., 2014; Blazer & Wu, 2009a). Thus, there was a gap in the literature on the drinking habits of MAs residing in ALCs according to the perspectives of their familial caregivers. This was the primary goal of this research.

The second goal of this research—reflecting another gap in the literature—was to determine whether the drinking habits of MAs affected their overall ability to successfully age in their ALC setting. As explained by Barry and Blow (2016), alcohol consumed in moderation is usually acceptable and does not pose what is considered in the field of public health to be a major health issue. However, the MA population, many of whom are taking prescribed certain medications and may have been diagnosed with certain health problems, can experience various complications from drinking alcohol,

particularly if they drink heavily (NIAAA, 2016). The results of this study sought to improve awareness of the impact of alcohol on the health and ability to successfully age in place of MAs residing in ALCs. The awareness gained from the results of this study may provide ALC administrators and staff, policy makers, MAs, familial caregivers of MAs, and medical professionals with information to support the argument that public health policies on alcohol consumption should be created to ensure that MAs residing in ALCs can successfully age in place.

The chosen research design was necessary to obtain an in-depth understanding of the phenomenon under study based on the thoughts of the familial caregivers being interviewed. The phenomenological approach as described by Starks and Trinidad (2007), provides a clear understanding of the facts primarily by presenting information that is oftentimes already known but still has a relevance to the phenomenon in question. I used this research design because it provided me with an ordinary meaning to the perspectives expressed by the familial caregivers of MAs about their description of the phenomenon of alcohol use in an ALC. Furthermore, this approach afforded the researcher with an opportunity to understand the lived experiences of the MA population based on the perspectives of their familial caregivers, and it uncovered commonalities in the thought processes of the familial caregivers who interact with the MAs who use alcohol in an ALC.

The key findings uncovered by this study were all connected to the perspectives of the familial caregivers of the alcohol consuming MAs residing in an ALC. I interviewed eight familial caregivers who resided in various regions throughout the

United States, as did their MAs. The participants were interviewed using a one-on-one, in-depth, semi-structured, face-to-face or telephone interview. Each interview was recorded and transcribed. After the audio recordings were transcribed and coded by the researcher, themes were generated based on the responses by the participants. The recognized themes are changes with alcohol consumption, overall health concerns and social interactions as a source of alcohol at the ALC.

The interview questions and processes were created and carried out as an effort to ensure that the most appropriate perspectives of the familial caregivers were represented in their responses related to the alcohol consumption patterns of their ALC dwelling MAs both in, prior to, and outside of their ALC. Through my investigation of the familial caregivers' perspectives of their MAs alcohol patterns, I wanted to determine the answers to developed research questions related to the MAs' daily experiences in their ALC, the role that loneliness or isolation plays in the MAs' decision to drink, challenges faced by the MAs in their ALC, and how the MAs' familial caregiver is able to identify when, where, and how much their MAs is consuming as it relates to their alcohol use.

This study's main findings related to the research questions uncovered some important information that would help support the argument that public health policies on alcohol consumption should be created to ensure that MAs residing in ALCs can successfully age in place. Four out of eight respondents noted changes related to their MAs' drinking habits since moving into an ALC. However, the changes in drinking habits varied widely. One noted that their MAs' drinking habits have increased since

moving into their ALC and three reported that their MAs drinks less since moving into their ALC. Another key finding included two out of eight participants believed there was an increase in alcohol-related falls in their MAs', one of which required surgery to repair a broken bone. The above findings based on the participants' responses suggests that, in many cases, the MAs' use of alcohol in their ALC affected their ability to successfully age in their ALC and is related to adverse health outcomes (i.e. falls and stomach issues).

Interpretation of the Findings

The purpose of this study was to explore the public health issue of alcohol consuming MAs who reside in ALCs and their ability to successfully age in their ALCs, as described by their familial caregivers. Successful aging, for this study, included how the familial caregiver viewed his/her MAs' aging process including longevity, life satisfaction, freedom from disability, independence, mastery and growth, and active engagement with life (Martin et al., 2015, p. 15). The findings generated from this study included revealing viewpoints that the MAs' alcohol use in their ALC does seem to impact their ability to successfully age, in various degrees. For example, participants reported that their MA was less likely to socialize with others in their community daily and more likely to isolate themselves in their rooms alone and drink. Also, it was reported that at least two MAs have had alcohol-related falls that resulted in injuries.

Halfon and Hochstein's (2002) life course health development model (LCHD) was used in this study as an investigative framework that provided focus for discussing the analysis of implementing processes in ALCs for the successful aging of MAs. This model is guided by four principles: multiple contexts of health development, design and

process of health development, mechanisms that account for variation in the trajectories of health development and integration of multiple time frames of health development (Halfon & Hochstein, 2002). These principles seek to provide an understanding of the risk behaviors and environmental agents that are encountered throughout people's lives and how these factors affect overall health and functionality of said individuals (Yu, 2006). Although, for this study, the researcher focused on the fourth principle, which suggests that experiences are conditional on the period in which they occur in a person's life (Halfon & Hochstein, 2002), it was uncovered that multiple contexts of the MAs' health development affected their ability to successfully age as well.

As it relates to the development and integration of multiple time frames of health development, MAs in this study were all, according to their familial caregivers, lifelong drinkers. Their drinking habits seemed to increase or decrease in relationship to life events. For example, six of the eight MAs experienced a life-changing experience such as the loss of a child or spouse. Each familial caregiver of a MA who experienced a loss of a child or spouse reported a direct relation to an increase in the alcohol consumption patterns of their MAs. Therefore, these findings suggest that emotional and situational stressors that occurred during certain timeframes of their lives influenced MAs' alcohol consumption based on such out-of-control stressors.

The LCHD model further argues that an individual's early experiences and their adaptive responses have a significant influence over their trajectory of health development that is not a deterministic effect (Halfon & Hochstein, 2002). The findings from this study, which did not go into detail about the MAs' early life experiences, did

conclude that early life experiences such as stressful jobs and strained marriages contributed to the MAs' drinking habits but did not result in any reports of damaging health diagnoses. The environmental insults of this model suggest that change can occur in gradual and independent manners or may cluster together in a socially patterned way (Ben-Shlomo & Kuh, 2002). This study, as per report, determined that there were no recognizable environmental insults as all MAs participants grew up in financially stable homes and became successful, college-educated adults who maintained good jobs throughout their adult lives. It was further reported by six out of eight participants that their MAs married well and had a stable relationship with their spouse. There was only one report of a volatile marital relationship that ended in divorce. Each of the participants in this study identified health concerns faced by their MAs. Per participant report, these health issues, such as fall-related injuries and digestive issues, are exacerbated by their MAs' drinking habits. As it relates to the multiple contexts of health development, this study proved that MAs' health concerns are not only affected by the aging process but are affected by their drinking habits as well.

It was determined through this study that a distinct relationship exists between the multiple contexts of health development, development and integration of multiple time frames of health development and the drinking habits of MAs residing in ALCs ability to successfully age. There was little evidence that design and process of health development and mechanisms that account for variation in the trajectories of health had a casual effect on their ability to successfully age. For future research, additional questions which focus on these principles of the model may shed light on implications for the life course and the

ability to successfully age as it relates to MAs who reside in an ALC and consumes alcohol.

Furthermore, in a study conducted by Hall (2008), adult children of alcoholics (ACOA) were interviewed to understand their perception of how relationships with kin and fictive kin affected their psychological well-belong as well as their experience of living with an alcoholic parent. Much like the study in which I conducted, the participants gave self-reports and were expected to retrospectively discuss events, feelings, and behaviors which means that they could have failed to disclose information that was too painful or would have shed negative light onto their family structure. Furthermore, Hall's study, like mine, showed that the perceptions of the familial caregivers, and the ACOA are important in gathering a complete understanding of the trajectories and multiple contexts of health development of the alcohol consuming individuals for whom they have grown up with and/or currently provide care.

The top three themes identified by the study participants were changes with their MAs' alcohol consumption habits in their ALC, overall health concerns both related and unrelated to their MAs' alcohol use, and the social interactions of their MAs both in and outside their ALC. According to Kuerbis and Sacco (2012), alcohol is one of the most abused substances by those who are 65 years of age or older. One main risk factor that contributed to this age group's unhealthy alcohol was late life retirement (Wang & Shultz, 2010). Wang and Shultz (2010) further expressed that retirement was an adjustment process in which the older adult must adjust to the changes that he or she

faced by deciding to no longer work and achieving psychological comfort within his or her newfound retired life (p. 177).

RQ1 sought to understand whether the familial caregivers had an awareness of the extent, if any, the MAs' daily experiences in their ALC contributed to their alcohol use. In this study, six out of eight knew that their MAs was drinking because of either a verbal or social cue; some were not sure about specifics as they lived so far away. Sasha noted that she is aware that her mother has possibly over-consumed when she speaks to her over the phone and notices that she is slurring her speech. She also explained that her mother, who prefers to drink in private, will tell her that she is ready for her to leave when she is there for a visit. From a demographic perspective, the information gathered from the participants as it relates to RQ1, held some similarities to what was uncovered during the literature review. For example, Sacco et al. (2015) concluded from a study conducted among continuing care retirement community (CCRC) residents that, most often, residents are socially motivated to drink amongst their peers, and this social motivation is stronger than their abilities to cope with painful life experiences and other forms of psychological distress. The residence itself may or may not contribute to more drinking: just one participant clearly stated that she believed her MA was motivated to drink more after disagreements with her neighbor. However, each participant was able to identify situational or emotional stressors that at some point have contributed to their MAs' use of alcohol prior to moving into their ALC. Therefore, it is important to note that all of the MAs who were discussed in this study had established drinking patterns prior to moving into their ALC community, and only one MA has had an overall increase

in her drinking habit since moving into their ALC because of conflicts encountered with a neighboring resident.

Sasha explained that her mother has always been an introverted “glass half-empty” type person who did not intermingle with others. Sasha further noted that her mother refused to get close to the residents who lived in her ALC because each time she becomes “friends” with someone, they “become ill and pass away or have to move to a higher level of care.” As a result, her MA isolated in her room and drank each day with little to no outside interaction with others. Based on the perspectives of the familial caregivers in this study, the MAs residing in ALCs are likely to consume alcohol as a coping mechanism to deal with mental and emotional stressors caused by outside factors or those created independently in their mind.

RQ2 sought information related to whether loneliness or social isolation, as perceived by the familial caregiver, affected the ability of the MAs to age successfully in place in their ALC. The results as related to RQ2 identified themes that aimed and confirmed that alcohol consuming MAs who resided in ALC experience periods of loneliness and oftentimes isolate themselves from their peers and consume alcohol alone in their private living space. These findings held a correlation to discussions in literature in which past research suggested that those who isolated themselves were plagued by limiting, longstanding illnesses, such as arthritis, depressive symptoms, and chronic lung disease (Steptoe et al., 2013). As it related to loneliness, the literature noted these individuals were also had broader range of health conditions such as a history of strokes, clinical depression, and coronary heart disease (Steptoe et al., 2013). Furthermore,

previous literature suggested that loneliness been linked to poor health, and the loneliness has a correlation to alcohol use (Canham, Mauro, Kaufmann, & Sixsmith, 2016). All eight respondents noted that their MAs were affected by varying degrees of health conditions to include but are not limited to arthritis, hypertension, vision impairments and history of stroke.

Along with major themes related to established drinking habits and overall health concerns, a third factor emerged, loneliness, particularly after retirement or the loss of a spouse. As suggested by the literature, one risk factor that contributed to unhealthy alcohol use among MAs was late life retirement (Wang & Shultz, 2010). Wang and Shultz (2010) further noted that because retirement was an adjustment process, and the MAs must adjust to these changes as a result of no longer working while achieving psychological comfort within his or her newfound retired life (p. 177). This is further aligned with the LCHD model, which suggests that the way people handle their life transitions could affect their overall health development, as well as their functional trajectories (2002). Jenny noted that although her mother began drinking alcohol in her early 30s, she was more prone to be social and participate in activities during that time. Since retiring, Jenny stated that her mother was adamant about not socializing and "says that she worked with the public all of her life and when she retired, she was going to do what she wanted to." As noted by Jenny, this is inclusive of not socializing or participating in activities in her ALC and drinking alone in her room most days. Summer, on the other hand, noted that she could vividly recall that her father drank more prior to retirement because he held a job that was "very hard for him and he would come home

and the first thing he'd want was a beer to relax and unwind." After retirement she believed that he drank more as a method of socialization than an actual satisfaction being received from drinking.

Some people consume alcohol not due to loneliness but for other reasons which can lead to alcohol abuse. According to the American Psychological Association (2016) alcohol abuse is one of the eight primary causes of death in older Americans, which includes the MA population. Six out of eight respondents noted that they were aware of others in their immediate family who were considered "chronic drinkers," and only two of the eight respondents noted that their MAs were the only ones who could recall consuming alcohol. Also, when asked their perception of alcoholism, whether they considered it to be a disease, addiction or mental health problem, the responses were wide range. One respondent considered alcoholism to be a disease and an addiction, two considered it to be an addiction and a mental health problem, three considered it to solely be a mental health problem and two considered it to be an addiction only. RQ3 sought to understand the emotional, physical and social challenges, as perceived by the familial caregivers, faced by their MAs while consuming alcohol in their ALC. The literature review uncovered very few studies conducted that focused solely on the MA population's drinking habits (Zanjani et al., 2013; Blazer & Wu, 2009; Sacco et al., 2014). Studies conducted by Blazer and Wu (2009) and Sacco et al. (2014), uncovered a clear association between binge drinking and being separated, divorced, or widowed. Studies conducted by Zanjani et al., (2013), Blazer & Wu (2009), and Sacco et al., (2014) however, disagreed on the notions that stressful events or cognitive declines cause an

increase in alcohol consumption, whether tobacco and illicit drug use was indicative of binge-drinking, and whether life events caused a change in an individual's lifetime drinking habits. Sacco et al. (2014) suggested that an individual's drinking problem possibly added stress to their lives as opposed to their being a direct causal relationship between perceived stress leading to an increase in their drinking. The results as it relates to RQ3 uncovered that the familial caregivers understood "challenges faced" to mean emotional, physical, and social occurrences faced by their alcohol consuming MAs in the ALC. All eight participants noted that their MAs faced emotional struggles in their ALC. Six of the eight participants associated these emotional struggles to be most closely related to the loss of a spouse and the loneliness that their MAs faced as a result. One participant noted that her MAs' emotional troubles were centered on the fact that she becomes "irrational and emotional" when she drank, and this caused her to drink more. Finally, one participant noted that her MA, although he drinks mainly only a social basis, thought a lot about his future without his wife and that "she is going to slowly slip away from him, and he's devastated." RQ4 sought to understand the familial caregiver's awareness of alcohol consumption by their MAs in the ALC. The familial caregiver participants understood "identifying alcohol exposure" to mean that they were aware of and could accurately describe their MAs' current alcohol use. In studies previously conducted by Chu et al. (2010) and Ekholm et al. (2011), it was suggested that self-reported alcohol consumption is a reliable method for identifying drinking patterns. The literature also suggests that an individual's ability to recall past week's drinking habits may not be reliable for sporadic drinkers, which includes those who drink less than four

days per week (Gmel & Daeppen, 2007). Therefore, with the ages of the participants in mind, it is easy to assume that they may not be able to correctly recall the number of alcoholic beverages they have consumed over the past week. However, after an exhaustive search of the literature, no study explicitly stated that adults could accurately measure amounts of alcohol consumed by others. Each of the eight familial caregiver participants were able to identify that their MAs consumed alcohol in their ALC community, but none were able to accurately account for an exact amount consumed. Sasha gave her account based on reports from her sibling who purchased the alcohol for her MAs. She noted that she was certain that her MAs "is a daily drinker," based on conversations that she had with her siblings. Based on reports from her siblings, she believed that her mother drank at least 3.785 liters of gin per week, all of which was consumed in the privacy of her apartment. This amount of alcohol consumption would be considered unhealthy, especially for those in the MAs age category of 65 and older. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) discovered in a 2008 survey that close to 40% of adults age 65 and older drink alcohol (NIAAA, 2016). Research also shows that alcohol consumption occurs in many ALCs, although the rate of consumption changes over time (Castle et al., 2012; and Klein & Jess, 2002). Combine these facts with the varying degrees of overall health concerns faced by MAs who reside in ALCs, and there is a public health issue. Not all MAs who reside in ALCs face issues with drinking outside of their limits or isolating themselves from others. For example, Winter explained that since her father moved into and ALC, his "alcohol intake has decreased so much because he is out of his room and is no longer lonely or bored."

Contrarily, Bella explained that if her mother was no longer able to consume alcohol it would be a "deal breaker," and that she "absolutely" believed that her mother drank more because of the ALC in which she resides. Familial caregivers in this study had concerns of their MAs' emotional and social well-being along with their overall health concerns in relation to the amount of alcohol they believed they consumed. The familial caregivers were able to recall past factors that have contributed to the drinking habits of their MAs, and they appeared to be active enough in the daily happenings of their MAs' life to give an accurate perspective of the thoughts on the drinking habits of their MAs in their ALC. Therefore, the findings from this research affirm and support principle four of the LCHD model and highlight the under-reported drinking habits of MAs in ALCs, their inability to successfully age as based on pre-existing medical conditions and limited motivation to participate in social activities in their ALC, and the overall disconnect present between the administration and staff of ALCs and their ability to recognize the drinking habits and patterns of MAs living in their community.

Limitations of the Study

There were several limitations as it relates to this phenomenological, qualitative study. Included in said limitations is the notion that this study used snowball sampling to obtain the total number of eight familial caregiver participants. Snowball sampling is not a limitation, but the sample population itself may not be a complete representation of the broader scope of the perception of familial caregivers as it relates the drinking habits of the ALC residing MAs. Based on estimates from July 2018, the U.S. Census Bureau (2018) reported that 60.4% of the United States was predominantly White and that

females accounted for 50.8% of the population. Although gender and race were not explored questions for this study, each participant identified themselves as a White female, which limits the generalizability of replicating this study's results across other populations.

Another limitation to this study was the accuracy of the familial caregiver's report on the amount of alcohol being consumed by the MAs in their ALC as these caregivers are not present for each encounter of alcohol being consumed by the MAs. Also, seven out of eight participants reported that they were not responsible for bringing alcohol into the ALC for their MAs from the community, but instead, either the MAs still purchased their own alcohol or had someone else purchase it. As a result, they cannot accurately note how often alcohol was purchased from the community and brought into the ALC by or for their MAs. In a phenomenological study, the researcher is provided with a clearer understanding of the facts by obtaining information that is often already known but is still relevant to the phenomenon in question (Starks & Trinidad, 2007). This approach suggests an ordinary meaning to the perspectives as expressed by the familial caregivers of MAs about their description of the phenomenon of alcohol use in an ALC. The phenomenological approach afforded the researcher with an opportunity to understand the lived experiences of the MA population based on the perspectives of their familial caregivers, and I was able to clarify the meaning behind a phenomenon as opposed to merely explaining or attempting to discover a cause (Penner & McClement, 2008).

Furthermore, it is important to note that there is very little research conducted on the MA population residing in ALCs, especially as to how it relates to their consumption

of alcohol and their ability to age successfully. While this study has limitations, it is meant to be a first step in the understanding of the impact of alcohol on MAs in ALCs and the call to action of further research on this important population and the effects of alcohol consumption in ALCs.

Recommendations

Several factors appear to be linked to alcohol use by MAs in ALCs based on the perspectives of their familial caregivers. These factors included but are not limited to the social, emotional and overall quality of health of the alcohol consuming MAs. The consideration of future research may be to explore specialized research questions that discuss these different factors such as the need for familial caregivers and ALC staff to keep track of alcohol purchases and monitor consumption habits in the ALC to help MAs better age in place. Therefore, it is important to have a more complete understanding of the alcohol use trends of older adults in order to more appropriately create public health screenings and interventions for what seems to be a growing public health concern among this population of individuals.

The overall goal of this study was to explore the public health issues of MAs who dwell in ALCs and consume alcohol as it relates to their ability to age successfully in their ALC based on the perspectives of their familial caregivers. The results of this research are expected to provide insight into the perspectives from the viewpoint of the MAs' familial caregivers as research participants, along with providing ALC administrator and staff persons, policymakers, MAs, familial caregivers of MAs and medical professionals with the necessary information to support the argument that public

health policies and interventions should be created to ensure that MAs in ALCs can handle their life transitions appropriately as to prevent an adverse effect on their overall health development. The focal point of future research may be to focus on the effects of interventions that are set in place to make sure that ALCs assist MAs and their familial caregivers with understanding the recommended amounts of alcohol to be consumed which could result in positive changes to improve the lives and the life expectancy of MAs who reside in these facilities.

Implications

The findings from this study can be used to develop more effective public health initiatives as it relates to policy development on alcohol consumption by MAs in ALCs. Such policy development will assist in educating the familial caregivers of MAs, ALC staff people and administrators who work closely with MAs. Additionally, policy development can assist MAs who consume alcohol of the importance of developing healthy drinking habits and understanding their limits in order to more successfully age in their ALC setting. This study was able to determine the social, emotional, and physical factors, such as the loss of a spouse, vision impairments and other co-morbid medical conditions, undiagnosed depression, short-term memory loss and a disinterest in social activities, as the most significant factors in determining whether MAs residing in an ALC and consuming alcohol had the ability to successfully age in place. Furthermore, the results of this study should play a role in helping design future public awareness programs related to alcohol use by MAs residing in ALCs, effective healthcare policies, and additional ways to modify or monitor the drinking habits of MAs residing in ALCs to

reduce their overall risk of potentially hazardous or self-injurious behaviors that would result in their inability to successfully age in their ALC.

The results of this study emphasized the significance of unmonitored alcohol use among MAs residing in ALCs as having a potential role in said MAs' ability to successfully age in their ALC. As a result, there should be a vested interest from different stakeholders, ALC policy creators, and administrators to more appropriately monitor and advocate for more authority in controlling the amount of alcohol that is in each MAs' individual room. Finally, further research is needed for a more in depth understanding of the combinations of risk factors regarding alcohol consumption among this population of individuals who are taking medications for varying degrees of medical conditions and spending limited amounts or time socializing with others in their ALC.

Implications for Positive Social Change

Findings from this study have the potential to create positive social change for an under-assessed public health problem in the aging population. The results may (1) improve public health awareness of the MAs ability to age successfully when they transition into and live in ALCs and (2) contribute to the information that currently exists about the drinking habits of MAs as perceived by their familial caregivers. The data collected and interpreted from the participants identified themes that will assist in potential evidence-based policy development on both a local and national level for this public health problem. The knowledge gained from this study can further be used to direct the public health education of medical and primary caregivers for this population, as well as staff person and administrators in their respective ALC.

Methodological, Theoretical, and/or Empirical Implications

There were no methodological, theoretical, or empirical implications for this study. The identified population consisted of familial caregivers of MAs between the ages of 65 and older, who had either had a genetic or marital relationship to the MAs for which they were reporting on, The identified population was sufficient and reasonable for addressing the gap in the literature that was outlined in Chapter 2 as it relates to the perspectives of the familial caregivers of MAs residing in ALCs and consuming age and their ability to successfully age. This study showed that qualitative interviews provided a positive way to gather data on this subject.

Summary

There are numerous factors that affect the ability to successfully age of a MAs, particularly those who reside in an ALC and consume unknown amounts of alcohol. Previous scholars have emphasized the role that alcohol plays in the successfully aging of community-based MAs, and few addressed continuing care retirement communities (CCRCs). This study highlights the need for additional research of this population in their "home" environment, as well as the overall policies that are currently in place for ALCs. The social change promotions expected from the results of this study can assist in the designation of future public awareness educational programs, effective healthcare policies, and ways to modify and monitor the drinking habits of MAs in their ALC.

Based on this study's data, public health policies regarding alcohol consumption by MAs in ALCs are needed in order to establish guidelines to help residents successfully age in place. The following are recommendations based on the results of this study:

1. Strictly limit where alcohol can be served and how much can be served at a given time. This would allow alcohol in a controlled environment. MAs would not be permitted to drink in the privacy of their own rooms/apartments and would not be able to drink in isolation.
2. Conduct regular wellness checks of MAs residing in ALCs to monitor weight gain/loss, mental health concerns, and other health related issues. Ask about alcohol use.
3. Have AA meeting availability at ALCs or nearby places where MAs can get the support they need.
4. Conduct more studies on the MA population and alcohol use and revisit recommendations as new data becomes available.

MAs make up a large subset of the population of the United States, and that this population of individuals continues to grow and deserves to be studied further to help them better age in place. Although it appears that MAs are financially prepared for their futures, they seem to lack an overall social and emotional preparedness for life after retirement. Even though their consumption patterns change over time, it is apparent that MAs are consuming alcohol in ALCs and the rates at which they are consuming said alcohol is underreported and potentially hazardous to their health and ability to successful age. If appropriate policies are not put into place by the federal and states who regulate ALCs, the public health impact of alcohol consumption in their communities will only dramatically increase as baby boomers reach MA age.

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Appendix A: Prescreening Questionnaire

1. Is English your primary language (i.e. verbal and written)?
2. Are you the child or the relative of adult aged 65-85 years?
3. Are you 18 years of age or older?
4. Does your parent or relative reside in an assisted-living community in the United States?
5. Does your parent or relative currently consume any amount of alcohol?
6. Has your parent or relative ever been told by a medical professional that they have Alzheimer's Disease, dementia, or any other cognitive impairment (issues with their memory)?

Appendix B: Interview Template

Rapport building:

1. Tell me a little about yourself and your family (i.e. married, children, how did you become the caregiver of a MA, etc.).
2. Are you currently employed?
3. What do you enjoy doing in your down time?

Experiences of the MA as perceived by the familial caregiver:

1. How often do you visit your loved one in their ALC?
2. What time of the day do these visits most often occur (i.e. morning, noon, night, or weekends)?
3. From your perspective, what was the primary reason your loved one moved into an ALC?
4. What would you say is your loved one's current state of health? Please describe.
5. From your knowledge, how does your loved one deal with taking their daily medications?
6. How do you feel your loved one's eating habits are in their ALC?
7. From what the staff has told you, what types of activities does your loved one participate in in the ALC?
8. From what your loved one tells you, what types of activities do they participate in in the ALC?
9. What types of activities do you participate in with them in their ALC, and how often?
10. What types of activities does your loved one participate in outside of their ALC?
11. What types of activities do you participate in with them outside of their ALC, and how often?
12. From your perspective, how long has your loved one been drinking?
13. Why do you feel your loved one consumes alcohol?
14. How do you feel your loved one's alcohol use affects their emotional state? Physical abilities?
15. What has been your experience with your loved one when they consume alcohol?
16. What do you feel are the challenges that your loved one most often has when they consume alcohol?
17. Describe for me a time when your loved one has over-indulged in alcohol in your presence.
18. From what staff has told you, do you believe that there might have been alcohol-related incidences of any type (e.g. falls, fights, etc.)? Please describe
19. How do you believe your loved one would cope if they were no longer able to consume alcohol?

20. From your perspective, does your loved one perceive how consuming alcohol will impact their life long-term? If so, how do you think this influences their alcohol consumption?
21. What is your perspective of alcoholism as a mental health problem, disease, or addiction?
22. To your knowledge has your loved one ever been told by a doctor or counselor that they have a drinking problem?
23. What do you feel is your loved one's satisfaction with their current quality of life?

Life Course Health Development Model questions:

1. Thinking back to your loved one's earlier years, can you identify a period or a specific event which may have led to an increase or decrease in your loved ones drinking habits?
2. From your knowledge, did/does anyone in your loved one's immediate family previously or currently consume alcohol? Please describe (i.e. relationship to the MA adult).
3. What is your perspective of your loved one's socioeconomic status as it relates to their drinking habits (i.e., do you think they drink based on their current or past income, job, or community in which they resided)? Please describe.
4. Do you think that your loved one's drinking has affected their ability to socialize appropriately with others, particularly with those in their ALC? Please describe.
5. From your perspective, has your loved one's drinking ever affected their ability to complete their activities of daily living (ADL's) (i.e. bathing, shaving, brushing their teeth, dressing themselves, etc.)?

Exit questions:

1. What are your hopes or concerns for the future of your loved one?
2. Would you like to be made aware of the findings from this study?

Debriefing:

1. How would you improve the research questions that you were asked? Please describe.
2. Were you affected by any of the questions that were asked (emotionally, physically, etc.)? Please describe.
3. Did you gain any knowledge from participating in this research study? Please describe.

Appendix C: Recruitment Flyer

You're Invited

My name is Lemeshia Agee-Chambers, MSW, and I am a PhD student in the Health Services Department at Walden University. I am conducting a research study in the United States about alcohol use among adults who currently reside in assisted-living communities.

I am seeking volunteer participants to conduct face-to-face or telephone interviews with. The interviews may last between 45-60 minutes. Timing is flexible, and each consenting participant is free to withdraw their consent anytime during the interview without any penalty. It is not necessary to identify the assisted-living community in which your loved one resides.

Criteria for this study includes:

- Child/relative of an adult aged 65-85 years
- Child/relative of a current assisted-living resident
- Child/relative of a current consumer of alcohol in the assisted-living residence

The Institutional Review Board (IRB) approval number via Walden University for this study is 02-28-18-0272439 and expires on February 4, 2020. If you or someone you know is interested in participating, please contact me at the information listed below.

You will be compensated for your time with a $100.00 Visa gift card.