**Introduction**

Due to advancements in health-promotion and disease-prevention, average life expectancy in the England is now 80.7 years (Raleigh, 2021). While longevity is no doubt an achievement for humanity, the success of modern healthcare creates “significant challenges for the future” of the National Health Service (NHS) and social care generally (Thompson, 2015, para. 5). 18.2 percent of the UK’s population for example, are now over 65 years old (Office for National Statistics [ONS], 2018). Additionally, the prevalence of alcohol misuse among older people in the UK is increasing (Royal College of Psychiatrists [RCPSYCH], 2018), with the problem being likened to a ‘hidden’ (Alpert, 2014) or ‘invisible’ (Sorocco & Ferrell, 2006) epidemic. The Harvard Study of Adult Development (2015), a longitudinal study dedicated to health and well-being throughout the lifespan, and now in its 82nd year, highlights AUD, along with dementia and depression, as one of the major health issues in old age. George Vaillant (2009; 2014), who was involved in the Harvard project for almost 50 years, found that approximately one-third of people in the study with AUD who had stopped drinking alcohol in midlife and subsequently maintained abstinence for decades, were mostly members of Alcoholics Anonymous (AA).

Although a considerable body of research has investigated varying aspects of AA, few studies have considered long-term recovery (LTR) in the context of aging and health. Fein and McGillivray (2007) did investigate LTR in the context of aging, but their research focussed on cognitive performance and not on health issues per se. Fein and McGillivray (2007) are an exception, LTR in AA has mostly been investigated from perspectives other than aging and health. Shinebourne and Smith (2011) for example, explored women with LTR in AA. While Gubi and Marsden-Hughes (2013) examined the therapeutic benefits of LTR. Gubi and Marsden-Hughes’ (2013) study also highlights how increasing numbers of AA members are maintaining LTR. In the UK, for example, the latest AA membership survey showed that 32% of an estimated membership of between 33,000 and 40,000, had been in recovery (AA, 2021a) for over ten years. The current study, therefore, aims to contribute to an under-researched area of healthcare by expanding our understanding of aging in the context of LTR.

Theoretically, the present study considers the narratives of the participants’ lived experiences from a logotherapeutic perspective (Frankl, 2014). Logotherapy is an existential and spiritual, meaning-centred psychotherapy. According to Holmes (1991) AA is essentially logotherapy because it addresses four of Frankl’s (2014) major concepts: the spiritual dimension, existential frustration, freedom and responsibility. Whereas Adlerian psychology and Freudian psychoanalysis, respectively, advance the notions of *the will to power* and *the will to pleasure*, as the fundamental forces that drive human beings, Frankl (1963) proposes that the individual’s instinctive “primary motivation” is “*the will to meaning*” (p. 105); that is, there is a deep-rooted instinct within every human being to find purpose and meaning in life. Frankl (2014) further proposes that when this basic need is not satisfied, people “suffer from a sense of meaningless and emptiness”, which he conceptualized as an “existential vacuum”, a phenomenon born out of boredom and apathy (p. 61). Equally central to logotherapy is the spiritual aspect of humanness, which in logotherapy is contextualised as *what it means to be human*. All of which, is particularly relevant to the elderly demographic in the current paper, who are likely to experience major late-life events that may cause them to question the purpose and meaning of their existence (e.g., bereavement of a partner, retirement, social isolation).

It has been suggested that people with AUD suffer from empty and meaningless lives (Chapman, 1996; Katsogianni & Kleftaras, 2015). The (seemingly obvious) solution to these existential crises, and key to recovery, is finding a meaning and purpose to life (Chen, 2006; Tonigan et al., 2001). Meaning and spirituality are central features in recovery in AA. At the core of AA philosophy is the notion that AUD is a “spiritual disease” (AA. 2001, p. 64), requiring a spiritual solution. These ideas echo both, the concept of an existential vacuum, and the “spiritually oriented” psychotherapeutic approach of logotherapy used to address it (Wong, 2012, p. 619). The simple AA twelfth-step action of supporting a fellow sufferer, confirms that spirituality is experiential: “The spiritual life is not a theory. *We have to live it*.” (AA, 2001, p. 83). AA members are also assured that “life will take on new meaning” (AA, 2001, p. 89). It is reasonable to assume that the spiritual values inherent in AA philosophy, are beneficial to individuals in LTR as they transition to later life. Thus, the current study seeks to explore how members of AA in the UK with LTR, experience and cope with the biopsychosocial and existential challenges that emerge in later life.

**Method**

According to Frankl (2014), logotherapy is an adaption of “the phenomenological methodology” (p. xvi). Guided by Frankl and the experience of previous research on the lived experience of AA members (e.g., Flores, 1988; Hill & Leeming, 2014; Medina, 2014; Shinebourne & Smith, 2009; Shinebourne & Smith, 2011; Swora, 2004; Zakrzewski and Hector, 2004), the appropriate method of exploration used in the current study is interpretative phenomenological analysis (IPA). Phenomenology has been described as a rigorous method of undertaking a subjective exploration of the true nature of self, alcoholism, and the life of the alcoholic, demonstrating that self and the world is continually being recreated as one journeys through life (Thune, 1977). Smith et al. (2009) point out that the purpose of IPA is to engage with theories, not test them. The individual meaning making that IPA uncovers, born out of the particular lived experience of the individual (Eatough & Smith, 2006), is something that cannot always be constrained within a theoretical framework. Because of the unique double hermeneutic method IPA uses, it has an “important and useful” role to play in research generally (Smith, 1996, p. 261), as it endeavours to make sense of people, who in turn, endeavour to ‘make sense of their major life experiences’ (Smith, et al., p. 1, 2009), many of which, occur in later life. In order to fully explore and analyse the experiences of shared phenomena, IPA guidance recommends working with a sample of between three to six participants (Pietkiewicz & Smith, 2014; Smith et al., 2009).

***Participants***

The participants in the study, therefore, were one woman and two men, who identified as being active members of AA. Their average age was 69; Claudia, Andrew and Jack (pseudonyms) have been in recovery and abstinent from alcohol for 21, 37 and 43 years respectively. Due to life circumstances (e.g., bereavement, divorce) they all live alone. All declared having long-term health conditions. Prior to each interview the participants were asked to complete an optional demographic questionnaire, before signing an informed consent form. In the context of the current study, LTR refers to somebody with more than twenty years continuous alcohol abstinence.

***Data collection***

The lead author approached prospective participants after AA meetings, briefly describing the study’s aims, before inviting individuals to participate. Those interested contacted the researcher, agreed to participate and were sent further information outlining the study in detail. Data was collected by recording face-to-face, semi-structured interviews, later transcribed verbatim. Interviews lasted approximately 40 minutes. Typically, semi-structured interviews are used in IPA studies, to collect rich, meaningful, qualitative data. An interview schedule was developed*,* usingopen-ended questions, encouraging the participants “to talk at length” (Smith et al., 2009, p. 59). The focus of the interview schedule was to explore the participants’ lived experiences of ageing and health-related issues in the context of LTR and AA membership. Questions posed included: *Having long-term recovery is a wonderful achievement. However, having XX years in recovery means that you are also XX years older. So, how do you feel about and experience getting older?* The schedule also sought to investigate the impact of ageing on the participants’ sense of self: *How important is your opinion of yourself as you grow older?*And**:** *What impact, if any, have the changes to your body and your physical appearance had on that opinion and on your self-identity?*

***Data Analysis***

The transcripts wereread several times, allowing the researcher to became familiar with the texts, and recognise potential themes, thoughts and meanings. These were recorded, carefully analysed and categorised into individual super-ordinate themes, which in turn, were further explored and clustered into higher-order group concepts. Verbatim quotes from the participants’ interviews are used in the results section of the report. The lead author identifies as being in LTR and, therefore, assumed a more active role in analysis and interpretation.

***Ethics***

The study was ethically approved by the University of Derby Online Learning Ethics Committee, and the British Psychological Society (BPS) Code of Human Research Ethics (BPS, 2014) was adhered to. The participants were assured they did not have to answer questions, and that the interview could be stopped at any time. The contact details of IAPT services (Improving Access to Psychological Therapies) were made available to the participants during debriefing after the interviews. Ethical considerations were further guided by Stake’s (2000) statement, that “qualitative researchers are guests in the private spaces of the world” (p. 154).

**Results**

Five higher-order group concepts emerged during analysis: *spirituality*, *being in the present*, *acceptance*, *self-esteem* and *fellowship: a support network*. Table 1 summarises the participants’ individual super-ordinate themes, while Figure 1 illustrates how they map on to higher-order concepts.

***[Table 1 near here]***

***[Figure 1 near here]***

**Spirituality**

AA emphasizes that their Twelve-step program of recovery is spiritual, not religious (AA, 2021b). At the beginning of his recovery for instance, Jack, who does not believe in either, religion or dogma, had a “*profound and sudden experience that gave me an insight and awareness of my true self*”. Most AA members, however, do not have such epiphanous experiences, and are more likely to undergo a gradual “spiritual awakening”, which develops “slowly over a period of time” (AA, 2001, p. 567). Moreover, because AA encourages personal agency, each member has a very personal understanding of spirituality:

*Great Spirit of the Universe. Everything, everything I do that I like doing and I enjoy doing enhances my well-being. Nourishes me really, nourishes my spirit, my psyche, my emotions...* (Jack)

*So, there’s always something on the horizon, or coming up for me, you know, and it all enhances my well-being, physically, mentally and spiritually, yeh.* (Jack)

For Claudia, her spirituality helps her to manage he pain, something which she has had to learn to live with, more or less, on a daily basis:

*… and it’s not a God of any doctrine, it’s spiritual. My spiritual faith is the universe, and that’s what I tap into every day and I often use the Serenity Prayer as a mantra, when I have been in pain and can’t get to sleep, you know, I will use it as a mantra, and before I know it, I’m off, I’m asleep.* (Claudia)

Andrew’s spirituality is contained within a more traditional religious framework, but his concept of the God of his understanding is not the one he was encultured with:

*My perception of God, or my relationship with the Higher Power that we have, I have, is completely different. I was going to be punished for everything; I’m not, I’m just a human being. I’m just here doing the best I can.* (Andrew)

*You know and I mention God, and with God’s help and everything else, that, that… I can do and get through one-day-at-a-time, thank God.* (Andrew)

**Being in the present**

Experience has shown the participants that negative emotional states, such as anxiety, are less likely to arise, if they make the mental effort to contain their lives within 24-hour time slots. *Being in the present* reflects the fundamental phenomenological concept of *temporality*, the way an individual consciously experiences phenomena (emotions, events, thought, etc.) as such phenomena arise and appear to them in everyday life. This guiding AA principle aims to keep the individual firmly rooted in the present. For a considerable time in recovery, Jack’s anxiety manifested both, physiologically and psychologically. Although no longer physical, anxiety emerges when his being moves away from the present moment:

*But it was very physical, I used to get physical pains, feelings, and that anxiety left me when I was about 10 years in recovery. But when I say anxiety today, it’s more like perhaps fear leading to, leading to periods of low, being slightly depressed about, well you know, I haven’t got much longer left. If I go out of the moment, out of the day, I think how much longer have I got left?* (Jack)

Claudia’s, anxiety arises because of concerns about her perceived inability to be able to undertake familiar tasks as she grows older, which she counteracts by anchoring her being in the present:

*I said to you just beforehand about as you get older, “how am I going to do this, how am I going to do that”?... and that’s things that you do have to let go of, because I can still tend to worry about that sort of thing. I just have to bring it back to the day, now.* (Claudia)

The concept of *being in the day* is a guiding principle of recovery. Andrew’s gratitude for AA and his recovery is apparent. For him, the meaning of *keeping it in the day* is, first and foremost, being in recovery one day at a time, but as his recovery gradually developed, the concept took on a deeper meaning. Indeed, for Andrew, application of this simple, temporal principle, is an existential necessity:

*I can now lead or live a life that I have that I wasn’t even thinking of before, and if I apply those, those principles and certain objectives of staying sober one-day-at-a-time and just keep it in the day, I will live.* (Andrew)

The concept of *being in the present*, is a mechanism for coping with the ageing process. Anxiety provoking thoughts concerning ageing and mortality are difficult to generate when Jack’s being is firmly rooted in the present:

*The older I get, ehm the more I savour and want to experience the moment and day. You know, just staying in the moment. Because ageing can sometimes be, it can be anxiety provoking. You know, one’s aware of one’s mortality much more than I ever was really. So, staying in the day or in the moment is something I nourish now.* (Jack)

**Acceptance**

Seen by members of AA as a spiritual principle (AA, 2001), acceptance has a pragmatic meaning for the participants. They are at a time in their lives when they are increasingly likely to experience poor health, so being able to easier accept negative health events is obviously advantageous. Additionally, acceptance is known to be an effective coping mechanism for pain management (e.g., Eisenlohr-Moul etal., 2013; Vowles et al., 2008). Nonetheless, the participants invariably have to face the health-related consequences of ageing on a daily basis:

*I also had hormone injections for the prostate cancer, and that was, I’ve finished that now, it’s all finished, but it, you know all my testosterone stopped, and ehm, so I’ve lost my, lost my libido, total, which is mixed blessings really.* (Jack)

*I used to say, ‘there was more, there was more of my body in St. Giles’ Hospital, than was walking around’, ‘cos they took, they took most of my stomach away, ﻿they took this away, they took that away. Again, isn’t it great, the body will learn to live with it? You know, and, and that’s exactly all I’ve done in my life, I’ve learned to live with what I have. That’s my experience.* (Andrew)

What appears to be a by-product of acceptance, resilience is a quality the participants have developed over many years in recovery. Resilience has proved to be a more than useful characteristic when coping with adverse health events:

*But the tumor, I’ll always be left with, I am left with just one ear that’s working, the other one isn’t, but my brain’s adjusting to that, and it’s, it’s working out quite well.* (Jack)

*Yeh, you do have to accept it, what’s the alternative if you don’t accept it: A life of misery? You know, and I don’t want that. It’s like people say to me ‘how do you manage your life being in pain every day [?]’, because I am in pain every day, you know? But it’s acceptance around it and I know that I have limitations on certain things that I can do, you know, but I can still have a go and try and do them.* (Claudia)

For the participants, mortality is, naturally, more prominent in their thoughts now, than at any time in their lives. Most of the time they do not dwell on thoughts of death, and experience a high degree of acceptance in the context of their mortality:

*…and I find that if I’m in the present, I’m not in the past or the future, I’m actually in the present, mortality takes its right place. You know it doesn’t, it doesn’t flood me with fear...* (Jack)

*So, I do think about death, but then I just think to myself, ‘well, when it comes, it comes’, and I can say that I’ve had a good innings, you know.*

*Andrew: Dying has no fear for me. The, the greatest fear I have in dying is who’s going to pay the bill ….* (Claudia)

Adopted by AA and used in mantra–like fashion to close meetings, the *Serenity Prayer* highlights the central and important role of acceptance in recovery in AA: “Grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference” (Alcoholics Anonymous, 1952, p. 41).

**Self-esteem**

In 1941, only two years after the book ‘Alcoholics Anonymous’ was published, Bowman and Jellinek (as cited in Kurtz, 2002), noted psychiatrists and pioneering researchers in the field of alcohol harm, believed there to be a link between ‘emotional maladjustment’ (p. 35) and people with AUD. Recovery, in contrast, is partly about finding ‘emotional sobriety’ (AA, 1952, p. 116), and developing self-worth (Strom & Barone, 1993; Suire & Bothwell, 2006), which Jack expresses succinctly:

*I think really, it’s the key to a lot of, a lot of life, the way one feels about oneself is essential to well-being and good living, you know*. (Jack)

It was while Andrew was volunteering in a second stage residential treatment setting, that he became aware that he no longer had self-doubt and low self-esteem:

*Yeah in kind, payment in kind, whatever. So, I knew I wasn’t going to make a living… but the living it was giving me… was, I was… my self-worth was coming into it. There was lads I was helping, lads and ladies that I was helping and talking to them. You know, and then I would hear, you know, ‘that Anthony didn’t half help me doing this, that and the other’. Wow ‘did I’! Isn’t that brilliant that I’m now becoming a useful man of society.* (Andrew)

Jack regards regaining one’s self-esteem as a naturally occurring process:

*The disease of alcoholism I believe is, robbed me of all that initially. Recovery was a process, is a process of many things, but it’s a process of getting my self-worth back, or getting what little I had back, and developing it really in all avenues of my life.* (Jack)

For Claudia, self-esteem means, that nowadays, she is confident enough to say *no*; a simple ability that low self-esteem had rendered her incapable of doing:

*And ehm, no, I’m not a door mat for anybody these days. And I’ve got the ability to say no and to mean no as well, and I never used to.* (Claudia)

**Fellowship: a support network**

As well as being antidote to the isolation associated with growing old, fellowship enables people to acquire a sense of meaning and purpose at a time of life when the individual is prone to both, change and loss (Kimble & Ellor, 2001). AA is essentially about identification and connection. In other words, it is about intersubjectivity. Read at the beginning of every meeting, the AA Preamble, which states: “Alcoholics Anonymous is a fellowship of men and women” (AA, 1947), signifies the central role of fellowship in recovery. The participants’ discourses indicates the importance of fellowship as they have grown older. As well as the friendship and support it offers, Claudia has found fellowship to be a practical coping mechanism. Fellowship is always close to hand, and is vitally important in helping Claudia to manage the chronic pain she has had to learn to live with:

*… there’s always someone you can talk to; you know you can pick up the phone and talk to … and there’s eh … The support in AA is amazing. When you’re on a low, even when you’re on a high, the support that you get from fellowship and the unconditional love that pulls you through, you know… Ehm, and makes you want to fight it, you know.* (Claudia)

Claudia’s lived experience of fellowship supports the phenomenological notion of intersubjectivity. In the context of phenomenology, intersubjective experience is viewed as being in the world in relation to others. According to Heidegger (1977), being-with-others (*Mitsein*) is a core value of human existence, it is not a product of cognitive development, rather it is of an *a priori* nature. Viewed from this perspective, it is easy to understand how recovery in AA is framed by intersubjective experience; the notion of one human being helping another to overcome common suffering. Being in the world in relation to others is a strong feature in both Andrew’s and Jack’s lives:

*You know I meet people in the Fellowship or related to the Fellowship and then something happens, and I do a, something like recently, the training work I’ve done in Scotland, and that was all indirectly, hem…causation was AA, was a man I met who was in the Fellowship.* (Jack)

*But I did it because I got help as well, it wasn’t just me. I have never been alone. You know somebody else has been with me, and guided, so I’ve just followed in their footsteps, it’s as easy as that.* (Andrew)

*… that loneliness inside yourself, there was no way to extinguish to, if you like, you know what I mean? I learnt to do that. It’s like some people call it defrosting, and I learned to defrost in the Fellowship, and, and let the sun in, if you like, let life in.* (Claudia)

Claudia’s summary shows how important fellowship is in later life, and how it has help to combat the isolation and the vacuum within.

**Discussion**

The current study focused on exploring the lived experiences of older members of AA in the UK with LTR, in the context of the biopsychosocial and existential challenges that accompany aging. The remainder of this section discusses and builds on the analytic interpretations presented in the results section and reflects on the meaning contained within the three higher-order group concepts discussed.

***Spirituality***

Recovery from AUD cannot be determined entirely by cognitive mechanisms: a ‘cognitive shift from drinker to non-drinker’ (DePue et al., 2014). Spirituality in AA is a major construct (e.g., Forcehimes, 2004; Garcia et al., 2017; Kurtz & White, 2015), and recovery depends on accessing cognitive processes in concert with the willingness to accept, in part, a spiritual solution (AA, 2001), defined as a “personality change sufficient to bring about recovery from alcoholism” (AA, 2001, p. 567) Kurtz and White (2015) refers to this process as “recovery spirituality” (p. 63). In the context of this study, recovery spirituality, can correctly be described as existential spirituality, the “courageous effort of (the) individual to confront suffering and create meaning” (Canda, 1988, p. 33); an apt description of the spirituality practiced by the study’s participants, which helps them to cope with, and negotiate the biopsychosocial challenges they have encountered in later life. Additionally, existential spirituality is associated with happiness and can helps cultivate an inner strength, which in turn can improve both, self-efficacy and coping abilities (Wade et al., 2018). Viewed from a phenomenological perspective, a personality change, something that the participants have developed during their decades spent in recovery, means they are “becoming aware” (Steinbock, 2004, p. 21). Indeed, a recently published longitudinal study, which began in 1995, found that personal growth is still important in later life, as it contributes to well-being and happiness (Toyama et al., 2019). Toyama and colleagues (2019) reported that spirituality and interpersonal relationships (i.e., fellowship) are important psychosocial factors as people grow older.

***Being in the present***

Between them, the three participants have over 100 years of continuous recovery, yet their lives remain centred within a time frame of one day: ergo, *being in the present*. AA encourages the individual to experience daily living as meaningful, similarly to logotherapy (Wong, 1997). When the participants first came into recovery, 24-hours had a pragmatic meaning, abstaining from drinking alcohol for a just a single day. For someone in early recovery not drinking for a single 24-hour period is a much easier temporal concept to understand and come to terms with, than the abstract notion of facing an entire lifetime without drinking alcohol; “*I didn’t know how to live in the day before I came to the fellowship*” (Claudia). As sober days become weeks, months and years, 24-hours takes on a different meaning, it is not just about abstaining from alcohol for 24-hours, it is about experiencing and living life one-day-at-a-time. Mindfulness, and other meditative practices have been adopted relatively recently as psychological interventions but *living in the now* has been a central component in AA philosophy since its inception in 1935. Claudia’s, Andrew’s and Jack’s experiences have taught them that negative emotions, such as fear and anxiety, are more likely to arise, if they are remorseful about past events or apprehensive about events yet to happen.

***Acceptance***

The temporal nature of life takes on greater meaning as one grows older. It is evident in the participants’ discourses that they have developed an accepting attitude towards their own mortality. Accepting the finiteness of one’s existence lends support to Frankl’s (2004) claim, that rather than highlighting the meaningless of life, death renders life greater meaning, “the meaning of human existence is based on its irreversible quality” (p. 75). A positive attitude towards the finiteness of human existence, means that tasks and plans are able to be accomplished, and “procrastination”, considered in AA (1952, p. 67) to be a character defect, is avoided: “*I’m not afraid of it. It’s going to happen to all of us, and I’ve got acceptance around that… Just get the best out of every day you’ve got, that’s the way I look at it now, because it is going to happen”* (Claudia).

Acceptance coupled with resilience, has enabled the participants to cope with the many negative health events that have emerged as they have grown older and that they continue to face, often on a daily basis. Moreover, acceptance is now recognized as an effective psychological intervention in the treatment of AUD (Acceptance and Commitment Therapy [ACT], Hayes et al., 2009). Thekiso, et al. (2015) for example, found that ACT, in tandem with inpatient integrated treatment, was beneficial to patients with AUD and comorbid affective disorder, and improved outcomes for abstinence, anxiety and depression. The simple phenomenological notion of accepting phenomena as it arises is evident in the discourses of the participants too: “*If I’m on a day where I’m feeling down, I just accept it: You are feeling down, it’s going to pass, go through it*” (Claudia).

***Self-esteem***

It is widely accepted, that among people with AUD, there is a prevalence to experience feelings of low self-esteem, and that they drink (excessively) to change these feelings (e.g., Glindemann et al., 1999; Scheier et al., 2000). According to Strom and Barone (1993) most definitions of AUD cite low self-esteem as a contributory factor. It is evident, that in common with other people with AUD, before they came into recovery, the participants in the study suffered from low self-esteem: “*I felt that I wasn’t good enough, or I couldn’t live up to peoples’ expectation*s” (Andrew). It is a commonly accepted maxim that in order to be able to feel affection for others, one needs to cultivate love of self (e.g., Gallagher, 1999; Seltzer, 2015;) Having a purpose in life, and the deep levels of self-acceptance and self-respect that the participants display, has enhanced their self-esteem, which in turn, enhances QOL and is beneficial for healthy aging (Sander et al. 2015). Moreover, self-esteem is significantly and positively associated with positive coping and loneliness in older adults (Zhao et al., 2017)

***Fellowship: a support network***

No doubt coincidental, it is nonetheless symbolic, that the first word in AA’s Twelve-steps is *We* (AA, 2001, p. 65). *We* implies and suggests fellowship, which in turn, signifies the end of loneliness and isolation, and which heralds the beginning of “a new kind of relationship with others” (Kurtz, 1982, p. 44). Fellowship is a form of social support, an important factor in helping older adults cope with depression (Potts, 1997), as well as other psychological problems and somatic health issues (Bøen et al., 2012). Moreover, social support is a reliable predictor of subjective well-being ((SWB); Diener & Seligman, 2002; Thomas, 2009). According to Siedlecki et al. (2014), SWB refers to how individuals experience their quality of life (QOL), cognitively and emotionally. Paradoxically, Thomas’ (2009) research which compared the benefits of giving and receiving social support, concluded that it was more beneficial for the SWB of older people to give than to receive social support. Indeed, as members of AA with LTR, the participants support newer members in early recovery. The participants’ narratives are testimony to the intersubjective nature of AA, which has afforded them the freedom to transcend the solitude the isolated *me* to become a part of the wholeness of the united *we*. At this stage of their lives, when they are more likely to experience health-related events, fellowship has greater meaning than ever, as a pragmatic coping mechanism. As Claudia simply states: “*I’m not on my own*”.

**Limitations and Future Research**

The study’s subject matter, LTR, ageing and health, is under-researched, and the addition of the current study makes an important contribution to explaining how people in LTR from AUD experience ageing and cope with health-related issues. One limitation of the study is that it was only possible to interview participants over one time point rather than over a longer period of time at different points. In this way, not only could more data have been collected but changes or consistencies within each participant could also have been captured. Although the sample size followed the recommendations of Pietkiewicz & Smith (2014) and Smith et al. (2009), who are instrumental in the development of IPA as a qualitative method of investigation, future studies in this area may benefit from the suggested upper limit of two/three more participants. That said, the study explored the individual lived experiences of three individuals and is not meant to be generalizable. It is recommended that future research may wish to consider a similar study, using elderly individuals who are not in a support group and have found LTR from AUD, via other routes, and compare their experiences of aging and health-related issues with people similar to those in the current study, who have achieved and maintained LTR in AA or other mutual support groups.

**Reflections**

As the lead author of the paper, I disclose my status as someone who has been in recovery for over 30 years and, therefore, identifies with the participants in the study. Moreover, I have lived experience of Frankl’s (2014) concept of an existential vacuum and its route cause, apathy. As an insider I have shared knowledge, something that an outsider is unable to gain (Rabe, 2003). On the other hand, my knowledge may have inhibited my ability to ‘bracket’ (the phenomenological technique of putting aside one’s personal experiences) any biases I may have about the research topic. To address this dichotomy, I was guided by Smith et al.’s (2009) advice, that “the positive process of engaging” with participants, should take precedence over bracketing concerns, in the assurance that ‘skillful attention to the former facilitates the latter’ (p. 35).

**Conclusion**

The participants’ discourses reveal they have developed a positive self-concept, something that is known to be beneficial to the psychological well-being of individuals as they transition to old age (Markus & Herzog, 1999). Additionally, both, LTR and AA have given, and continue to give their lives meaning and purpose, which in turn, enables them to cope with the challenges that invariably accompany the aging process. The overarching AA ethos of meaning and empathy, is concisely summed up in the concluding statement of the AA (1947) Preamble: “Our primary purpose is to stay sober and help other alcoholics to achieve sobriety”. Aging in recovery is an under-researched area, the knowledge revealed in the participants’ narratives can inform both, alcohol and treatment services, and healthcare professionals about the coping mechanisms that elderly individuals in recovery use to cope with the challenges they face later in life.

**Data availability statement**

The data that support the findings of this study, and also the interview schedule, are available on request from the corresponding author, (KM). The data are not publicly available because they contain information that could compromise the privacy of research participants.

**Declaration of Interest**

The authors report no conflicts of interest with respect to the research, authorship, or publication of this article. The authors did not receive any financial support in the form of grants in relation to the research, authorship, or publication of this article.

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