

Exploring Women's Perspectives on Alcohol Misuse, Treatment, and Priorities for Research: Qualitative Findings from the WomenWise Project

Brianna N. Tranby

Mayo Clinic

Audrey G. McGuinness

Mayo Clinic

Christina M. Smith

Mayo Clinic

Tessa Vance

Wisconsin Women's Health Foundation

Tommi Thompson

Wisconsin Women's Health Foundation

Matthew Samocki

National Network of Depression Centers

Chuck Strand

Rural Minds

Philip Vonada

National Grange

Colleen D. Young

Mayo Clinic

Kasey R. Boehmer

Mayo Clinic

Alanna M. Chamberlain

Mayo Clinic

Christi A. Patten

Mayo Clinic

Pravesh Sharma

sharma.pravesh@mayo.edu

Mayo Clinic

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Abstract

Background

Women remain underrepresented in alcohol use disorder (AUD) research despite sex- and gender-specific health disparities and barriers to treatment. Community-engaged approaches can identify opportunities for patient-centered comparative effectiveness research (CER) that reflect women's lived experiences. The WomenWise project used community engaged, bi-directional, partnered learning sessions (PLS) to qualitatively explore women's perspectives on alcohol misuse, treatment barriers, and priorities for future CER.

Methods

In 2025, we conducted five 90-minute PLSs via Zoom with attendees who were aged ≥ 18 years, self-identified as a woman, reported lived experience of alcohol misuse, were a family member/caregiver of a woman with AUD, and were affiliated with a WomenWise partner organization or a healthcare provider treating AUD. Moderated PLSs focused on bi-directional knowledge exchange and sharing of experiences. Audio transcripts, Zoom chat content, and one asynchronous online discussion thread were analyzed using reflexive thematic analysis. Suggested future CER topics generated during sessions were presented to the WomenWise community advisory board (CAB), which ranked priority topics by vote.

Results

In total, 51 attendees shared their experiences. The major themes centered on a sense of shame and stigma unique to women, with many attendees mentioning gendered norms, "mom culture," "quiet drinking," and caregiver role strain. Barriers to treatment included structural challenges, poor healthcare provider communication, the need for trauma-informed care, and concerns about privacy particularly in rural areas. Six future CER topics emerged, of which the CAB selected three priorities: (1) harm reduction/moderation versus abstinence-only approaches, (2) trauma-focused care versus standard AUD treatment, and (3) care access and engagement strategies.

Conclusions

These bidirectional, co-learning sessions identified patient-centered, community-informed priorities for future AUD research in women. The findings highlight the importance of addressing stigma, trauma, structural barriers, and provider communication when designing future women-centered treatment studies and care models.

Background

Alcohol use disorder (AUD) is an important public health issue in the United States (US) that affects physical and mental health across populations.^{1, 2} Women's unique experiences, in particular, are shaped by a range of socio-demographic and psychosocial factors, highlighting the need for tailored approaches to prevention and treatment.^{3, 4} In 2024, an estimated 10.7 million adult women in the US had AUD in the past year.⁵ Men have historically used alcohol and received AUD diagnoses and treatment at higher rates than women, despite the fact that women experience greater sex-specific alcohol-related health disparities.^{3, 6} Moreover, prior research on AUD has focused disproportionately on men,⁷ thus both clinicians and individuals who misuse alcohol are likely underinformed on how alcohol use differentially affects women.³

Patient-centered clinical comparative effectiveness research (CER) is a method well-suited to addressing this complexity by involving more women with lived experience in setting priorities for women-centered AUD research.^{8, 9} This method recognizes the knowledge and strength of women with lived experience and produces data that can address structural and sociocultural inequities. Unlike traditional clinical trials, patient-centered CER considers the effects of population differences on the efficacy of existing treatments. Moreover, community-based research approaches emphasize the importance of equitable knowledge-sharing partnerships between community members and researchers.^{10, 11} This bidirectional exchange is central to community-engaged research methods, helping to safeguard historically marginalized populations while translating research into new treatments and prevention strategies that align with community priorities.¹²

WomenWise is a capacity-building project developed to address the underrepresentation of women in AUD research.¹³ WomenWise leverages connections with an existing project-specific community advisory board (CAB), community partner organizations across the US, and community members and healthcare providers with lived experience to facilitate co-education to improve future patient-centered CER on AUD in women. Focus groups are a well-established qualitative method for obtaining feedback from community members to explore problems and potential solutions through the sharing of knowledge and experiences.¹⁴

This report describes our experience conducting five partnered learning sessions (PLSs) and the results from thematic content analysis of the sessions. PLS attendees provided valuable insights based on their broad experiences with the stigma and barriers to treatment that women with AUD often face, as well as specific recommendations for future CER topics.

Methods

Project Setting and Partner Organizations

This project was submitted to the Mayo Clinic Institutional Review Board which determined that the project was not human subjects research and was exempt from review and obtaining informed consent

(IRB: 24-004906). The project was funded through a Patient-Centered Outcomes Research Institute (PCORI) Engagement Award and led by clinical research teams in the Mayo Clinic Health System (MCHS), Northwest Wisconsin, and Mayo Clinic, Rochester, Minnesota. Prior to funding, the team had identified several partner organizations and community members to support the project including the National Network of Depression Centers¹⁵ (NNDC), the Wisconsin Women's Health Foundation¹⁶ (WWHF), The National Grange and Rural Minds¹⁷ (NGRM), Mayo Clinic Connect¹⁸ (MCC), the Mayo Clinic Center for Clinical and Translational Science¹⁹ (CCaTS), and local faith-based groups. During project development, partner organizations were asked to choose CAB representatives who would also be willing to serve as co-hosts during the PLSs to support trust-building.¹³

Attendees

Five PLSs were held in the summer and fall of 2025. Four partnered organizations (NNDC, WWHF, NGRM, MCC) recruited attendees through their existing networks. Outreach methods included email invitations, monthly newsletters, and social media posts. Attendees were eligible if they identified as a woman, were age 18 years or older, and either had lived experience with alcohol misuse, were a family member or caregiver of a woman with alcohol misuse, or were a healthcare provider or trainee specializing in alcohol treatment. Online registration was capped at 15 attendees per session to allow adequate time for discussion.

While the first four PLSs were attended by both women with lived experience of alcohol misuse and alcohol treatment providers, the project team felt that the unique perspectives shared by healthcare providers warranted further exploration. Thus, a fifth PLS was organized through online recruitment with female healthcare providers (HCP) in the MCHS catchment area who specialized in alcohol treatment.

Partnered Learning Session Overview

The project team and WomenWise CAB created PLSs to bring together community members' lived experiences and researchers' knowledge to strengthen alcohol misuse research among women. Five PLSs were co-hosted with partnered organizations. The 90-minute sessions were held via Zoom on weekday evenings to accommodate attendee availability and location. Each PLS was moderated by up to three members of the project team (BT, AM, PS) and co-hosted with one or two CAB members from each partnered organization. Attendees and co-hosts were mailed a \$150 prepaid cash card in thanks for their participation.

Each session opened with an introduction to the moderator(s), the partner organization co-host(s), and the WomenWise project itself. In the first 15–20 minutes, the co-host from the partner organization presented information via PowerPoint on alcohol misuse among women and key gaps in current research. During the next 15–20 minutes, the moderators presented didactic education on general

research methods (e.g., quantitative, qualitative, mixed methods), research ethics (e.g., informed consent, the Belmont Report, etc.), and patient-centered clinical CER.

Each session then transitioned to a facilitated discussion similar to an online focus group.²⁰ Attendees participated in an icebreaker activity to introduce themselves to the group. The moderators then presented questions on three specific content domains with prompts to facilitate discussion among attendees: 1) Shame and stigma unique to women, 2) Barriers to treatment for women, and 3) Future research priorities.

In the last 10–15 minutes, moderators asked attendees to suggest five topics that they would like to see future CER examine. Attendees were encouraged to provide specific ideas for CER studies in which one type of treatment or approach would be compared to another. An example was provided for clarity (“Example: comparing women-only support groups versus mixed-sex groups in alcohol treatment”) but all suggestions were welcomed and valued (see Fig. 1 for details).

Follow-up Survey

PLS attendees were emailed a link the following day to complete a brief follow-up survey in REDCap to assess satisfaction and obtain feedback. Four items specific to this project assessed satisfaction with the PLS overall, the extent to which they learned new information about alcohol misuse in women and the importance of patient-centered research, and whether the group discussion was informative and productive. These items were rated on a 5-point Likert scale (strongly agree, agree, unsure, disagree, strongly disagree). Two open-ended questions asked for feedback on something they enjoyed about the PLS and what would have made it better (see **Supplementary file**). These comments were summarized by the moderators for common themes and used to iteratively refine the didactic education and discussion prompts between PLSs.

Qualitative Analysis

The PLSs were recorded and fully transcribed. Data for the analysis included five de-identified PLS transcripts and concurrent Zoom chat records. The Mayo Clinic Connect platform offered a unique opportunity to foster ongoing discussion for the MCC PLS. The partner organization co-host opened a private message thread with attendees from the MCC PLS to continue their conversation virtually during the week after the PLS, and the record from that asynchronous discussion was also included in the analysis.

An iterative, reflexive qualitative analysis using Reflexive Thematic Analysis (RTA) was conducted by a single analyst (CS).²¹ Data were imported into NVivo (Version 14) to facilitate coding, memoing, and theme development.²² The analyst repeatedly reviewed transcripts and chat content to achieve familiarity with the data and documented emerging interpretations through reflexive memoing. Inductive

coding captured both semantic and latent meanings, with codes iteratively revised as analysis progressed. Codes were subsequently grouped into themes which were refined through repeated engagement with the data, with attention to divergent perspectives and experiences. Consistent with best practices,²¹ the thematic analysis focused on meaning-making, reflexivity, and interpretive depth rather than inter-coder verification.

CAB Feedback on Priority Research Topics

The results from the qualitative analysis and suggestions for future CER topics were presented to the WomenWise CAB on February 23, 2026. During the meeting, members discussed the suggested CER topics and asked clarifying questions. A recording of the session was made available for members to rewatch later if needed. After the meeting, each CAB member voted electronically through REDCap to select the top three topics, in order of priority, that they felt were most significant to recommend for future research.

Results

In total, 51 attendees participated from multiple states and one Canadian province (see Table 1). All attendees and organization co-hosts self-identified as women and met eligibility listed above, but additional demographic data were not collected. While each session followed the same broad format (e.g., education on alcohol misuse, research methods, and ethics; group introduction; discussion with moderator prompts), moderators iteratively refined the content between sessions based on attendee survey feedback. For example, early attendees suggested spending less time on general research education and more time with discussion on prevention and effective treatments. Additionally, the first two PLSs were led by the male principal investigator (PS), but the last three were led by female project coordinators (BT, AM) after some attendees shared they would have felt more comfortable having the sessions run by women.

Analysis generated three overarching thematic domains corresponding to the discussion topics, with 11 interrelated sub-themes identified across the dataset. Quotes are reproduced verbatim from transcripts, and additional illustrative quotes are included in Table 2.

Shame and Stigma Unique to Women

Gender Norms and “Mom Culture”

Attendees described that alcohol use is commonly interpreted through gendered social norms. Men’s drinking is often normalized, minimized, or excused, whereas women’s drinking is subject to heightened scrutiny, moral judgement, and assumptions about personal responsibility or character despite the simultaneous rise in alcohol marketing directly targeting women.

“Mom culture” was specifically referenced and described as mothers needing alcohol to deal with stress. One said, “I’ve noticed something about the whole mom culture... ‘Mommy needs a glass of wine,’ and that it’s just impossible to parent without it.... Mommy needs support and not a drink.” (NNDC1).

Some attendees shared that the education on alcohol misuse that had been shared at the beginning of the PLS had been enlightening. While some had known that alcohol is processed differently in female and male bodies, they mentioned that there are still social pressures based on gendered expectations about drinking.

Shame, Stigma, and Quiet Drinking

Attendees described a contradictory cultural script: women are encouraged to drink through excessive marketing of alcohol as self-care and an acceptable coping mechanism, but at the same time they are punished socially when their drinking becomes visible or problematic. This shame contributes to concealment, underreporting, and delayed help-seeking. As one attendee stated, “Women will drink at home...versus goin’ out to a bar.” (MCC5). Another echoed, “There is more drinking among women, but it’s still a secret.... They’re just still hiding it.” (NG/RM1)

Caregiver Strain and “Superwoman” Expectations

The shame associated with alcohol misuse in women is often tied to the unique experience of motherhood or caregiving roles. Caregiver expectations put additional pressures on women to “hold it together.” As one attendee shared, “Motherhood is a beautiful thing, but it’s depressing, especially when it comes to postpartum. I feel like, when a woman drinks, it’s because they feel like the world is on our shoulders and that they’re not enough.” (WWHF1). For women who feel pressure to be “superwomen,” asking for help can feel like failing in a role tied to their self-worth. A provider shared that they try to encourage their clients that:

...they don’t need to be superwoman.... It’s okay to ask for help. It’s okay that they are engaging in these services and talking with people about what they’re going through.... They don’t need to be this concrete to hold everything together. It’s okay to take those steps for themselves, too. (HCP6)

Barriers to Treatment for Women

Structural Barriers

Attendees observed that treatment access for women is often limited by structural and systemic barriers including childcare coverage, fear of involving child protective services, insurance and cost, scarcity of women-specific programs, and confidentiality especially in rural areas. One commented, “Many women don’t go to rehab because there is no childcare at the facility.” (MCC3). A provider said, “I work with the OB population, so I could see them a little more hesitant than others just for fear of CPS involvement, or even being judged by others because they’re a parent struggling with AUD.” (HCP4).

Missed Clinical Opportunities

Attendees who had sought treatment also noted failures in the healthcare system such as lack of training in AUD among primary care and emergency medicine providers, stigmatizing responses, and inadequate follow-through. One attendee shared her personal experience:

The way that women are treated in healthcare systems already has a lotta problems. Going into seeing a doctor, I always feel like they...assume that my physical pain is because of psychosomatic reasons and not actual real medical reasons. If I even admit that I have alcohol use disorder, then that means they will blame that for everything.... worrying constantly about having that in my chart and how that will affect the way they treat me for important medical decisions is a huge impact for me. (NNDC6)

Another attendee stated that when medical providers ask about alcohol or drug use, the phrasing does not seem to invite open conversation:

Most of my providers say things like, “You’ve never used illicit drugs and you’re not a drinker, right?” They don’t leave it open for me to say, “Well, maybe that’s changed from previous.” It’s more like a pushing a button that you have to push. (NGRM4)

The Importance of Good Communication

Alcohol dependence treatment providers and other attendees described clinicians minimizing or shaming women when they sought help. One shared, “It took four trips to the ER with AFib.... One of the doctors said, ‘Well, you don’t look like an alcoholic.’ They just dismissed it.” (NNDC4). Another shared:

I had been admitted through the ER with a very high BAC, so there was no doubt about my drinking.... My PCP looked over my ER history, including elevated liver enzymes, and said only that he hoped I had learned my lesson... It would have been a good time to suggest treatment. (MCC4)

Attendees also discussed types of communication that had been helpful for allowing women to open up without fear of judgement. Motivational interviewing and relationship-based communication, that can reduce shame and increase safety, were seen as essential – but not always easy to find. When asked what might make women more comfortable sharing their drinking habits with a provider, one said, “A good relationship with provider. [But] With the trend in Primary Care where you see different provider every visit, you do not develop trust.” (MCC3). A provider also discussed their own intake process:

One thing I always do during my intake is explain that my role is harm reduction and it’s not to judge them. Then I try to get together with whoever referred them to talk through the stigma and the judgment that happens and how we can best support them. I am very passionate [that] if we’re able to meet them where they’re at, they’re going to keep seeking out healthcare services, and that’s going to be better in the long run. (HCP4)

Actionable Linkage to Care

Similar to the importance of supportive communication from clinicians, the importance of follow-up care was emphasized. As one provider noted, “Often reading charts, you’ll see, especially if they go to the

emergency department, 'medically detoxed.' But there is no note of where the follow-up was. Was there any talk of going to an outpatient...[or] inpatient treatment? There is no follow-up." (HCP13).

Attendees suggested that referral systems should function like cardiology and oncology referrals to offer immediate scheduling, embedded behavioral health, and structured follow-up rather than passive advice. One attendee suggested that a warm hand-off may be helpful. "Even saying to the client, 'If you go out front here, I'll give you the resources, and you can ask one of our people up front to help you make that first phone call before you ever leave the office.'" (MCC1).

Trauma-Informed and Whole-Person Care

Alcohol misuse was repeatedly framed as being intertwined with trauma and mental health (e.g., depression, anxiety, postpartum, bipolar, etc.). One attendee shared, "I think that a lot of this is, as women, we don't talk about this because when we go through something traumatic, we're either told to shut up or sweep it under the rug." (WWHF1). Attendees emphasized that effective care must treat underlying issues, not AUD alone. As one stated:

I think you also need to treat the whole person. You can't just say, "Okay, you have an alcohol use disorder. Let's treat that. Okay, now you're fine," because there's lots of things that play into that. Did mental health cause the alcohol use disorder? Did alcohol use cause the mental health problems? There's significant trauma in so many people now and I think again, you have to really treat everything. You can't just treat one piece of the person.... (NGRM1)

Privacy and Confidentiality Concerns

Concerns about privacy and confidentiality were mentioned related to alcohol use screening questionnaires, seeking treatment, and participating in research, particularly in rural areas. One shared her experience with being given a screening questionnaire while waiting at the doctor's office:

They've started switching to it's all online,...but before that, they just gave you the paper and anybody and everybody could see that and I just was like, "I'm not filling that out." I'll talk to the doctor about it if I need to, but I wasn't comfortable just filling out an assessment tool. (NGRM2)

Future research priorities

Research Participation

Themes that emerged included trust in who invites the participation ("...they have to be invited by someone [they] trust"; HCP11), low-burden study designs ("...making it convenient, making it easy."; HCP3), privacy protections ("ensuring absolute anonymity...is crucial"; MCC2), "seeing more women-led researchers" (WWHF3), and transparency about how the information will be used ("I would like to know the results of this research"; NNDC2).

When asked what research teams can do to make women feel more comfortable taking part in research, one attendee replied:

I think stressin' how important it is. You have to get outta your comfort zone to participate. That's not an easy thing to do. I think impressin' on people, women, how important this research can be for not only ourselves as we participate in research, but for others followin' behind us. (MCC5)

Tailoring Research to Women's Needs

Attendees felt that research and treatment should be tailored to women's unique needs, specifically culture, identity, and life stage often shape alcohol misuse and willingness to seek help. For example:

[The LGBTQIA+] community suffers a much higher rate of substance abuse disorder than the general population.... members of this community don't know where to turn for help kicking their habit.... This suggests that a communications and/or marketing effort should be first and foremost in any strategy designed to increase the awareness of substance abuse disorders. If you can't get them in the door, everything else is a moot point. (MCC6)

Cultural aspects should also be considered. One provider suggested training community health workers to identify alcohol misuse in women because they often see pregnant women, mothers with young children, and elderly women. She noted that specifically, "In the Latin culture, it's hard to address these issues because they feel they are limited. There are some boundaries to address that because it's not culturally acceptable." (HCP11). Several attendees also discussed the importance of taking into account the life stages that women experience. One provider noted:

I really like the approach of different research on the different stages. Like high school stage, early workforce, parenthood.... But then also the hormonal stages that a woman might go through, and how that's impacting...their inability to cope with some of the things that they might be going through. (HCP1)

PLS Follow-up Survey

In total, 34 of the 51 (67%) PLS attendees completed the follow-up survey. Overall, attendees reported being very satisfied with the PLS and felt that the group discussion was informative and productive (see Fig. 2). Nine attendees (27%) disagreed or were unsure about learning new information about alcohol misuse in women, but a few noted in open-ended responses that they were either treatment specialists or otherwise had extensive knowledge and experience. When asked what they enjoyed about the PLS, the most common themes were: a) hearing personal stories and experiences from others, b) valuing the discussion between women, c) having a variety of perspectives represented, and d) connecting with other providers. Attendees also felt that the sessions had been well-moderated and enjoyed learning about ongoing research.

Suggestions for improvement were having more time for open-ended discussion and recommendations for additional content topics (e.g., prevention, dual-diagnosis). Two attendees noted having technology issues on their end, and a few had suggestions to improve the moderation or flow such as sending the

discussion questions or slides before the meeting to give attendees more time to consider their answers.

Comparative Effectiveness Research Priorities

The topics that attendees proposed for future CER were richly varied and focused on comparing real-world treatments, life-stage tailoring, identity-concordance, integrated care, and social support. Their practical “A vs. B” comparisons highlight the need for approaches that are better aligned with trauma histories, social determinants of health, and flexible treatment models.

Six main topics emerged as research priorities across the sessions: 1) Medication Treatment vs. Psychotherapy, 2) Trauma-Focused Care vs. Standard AUD Treatment, 3) Family or Couples' Treatment vs. Individual-Only, 4) Harm Reduction/Moderation vs. Abstinence-Only, 5) Care Access & Engagement: Remote Support Plus Proactive Navigation, and 6) Identity-Concordant vs. Open-Access Groups (see Table 3 for details).

CAB Vote on Priority Topics

Between February 25 and March 9, 2026, 10 CAB members completed the voting survey. Votes were ranked by weighted score (Points assigned: Priority #1 = 3 points; Priority #2 = 2 points; Priority #3 = 1 point). Figure 3 shows the results of the vote. The three topics identified as the top priority areas were: 1) Harm Reduction/Moderation vs. Abstinence-Only, 2) Trauma-Focused Care vs. Standard AUD Treatment, and 3) Care Access and Engagement. These results were shared back to PCORI for broader community dissemination.

Discussion

The aim of this project was to explore women’s experiences with AUD, identify barriers to care, and generate priorities for future patient-centered CER. To that end, we worked with partnered organizations to invite women and healthcare providers with lived experience to participate in five co-learning sessions. Attendees described how women’s alcohol use is shaped by gender role expectations and stigma, caregiver strain, trauma history, structural barriers to treatment, and negative experiences in the healthcare system. They also highlighted practical considerations for engaging women in research and identified actionable areas for future CER.

A central theme across sessions was the persistent influence of gender-based shame and stigma on women’s alcohol use. Consistent with prior research, attendees described contradictory social norms in which alcohol use is normalized and marketed to women, particularly through “mom culture,” while women are simultaneously socially ostracized when alcohol use becomes problematic.²³ The repeated discussion of “quiet drinking” and concerns about being perceived as a “bad mother” or caregiver were consistent with prior literature demonstrating that women with AUD often fear social consequences which leads to concealed alcohol use, delayed treatment-seeking, and underdiagnosis.^{24, 25}

Attendees also identified structural barriers to treatment for women such as childcare limitations, treatment affordability, and fears related to child protective services. Shortcomings in healthcare encounters, including missed opportunities in screening, dismissive clinician attitudes, and stigma within healthcare settings also align with prior work showing that women with AUD encounter healthcare environments that are fragmented or insufficiently responsive to their needs.^{4, 26, 27} Attendees emphasized the importance of communication style, specifically that clinicians should foster an environment of trust and use nonjudgmental language. Motivational interviewing was suggested to facilitate disclosure and engagement in care. Recommendations for “warm handoffs” and proactive scheduling also align with existing literature that women may benefit from more active person-centered approaches to care rather than passive referrals alone.^{24, 25}

Our findings also provide practical considerations for designing more inclusive research studies. The themes of underlying trauma, subgroup identity, and co-occurring mental health disorders reinforce the importance of whole-person and trauma-informed approaches to AUD. Interventions which focus too narrowly on alcohol use without attention to emotional and psychological needs may be insufficient for many women. Attendees also expressed a preference for research invitations coming from trusted individuals or organizations, low-burden participation options, and clear explanations about how research findings will be used. The importance placed on representation (e.g., women-led research teams and culturally responsive approaches) suggests that interventions designed without attention to identity, lived experience, and context may not fully address women’s experiences with AUD.

Patient-centered CER is well-suited to addressing questions where evidence is not yet tailored to women.¹² When PLS attendees were asked to propose real-world comparisons between treatment options for women, several of the topics reflected tensions between existing care paths and women’s expressed preferences. The resulting topics were selected by the WomenWise CAB to recommend future research on 1) harm reduction versus abstinence-only approaches, 2) trauma-focused care versus standard AUD treatment, and 3) strategies to improve care access and engagement. The CAB voting process further strengthened the patient-centered nature of priority-setting by moving from broad discussion to a focused ranking process.

This project has several strengths. Attendees participated from 18 states and 1 Canadian province, representing a broad spectrum of backgrounds and perspectives. The educational content provided at the start of each session appeared to facilitate discussion by creating shared context and language around research concepts while still being centered on attendees’ lived experiences. Attendees reported high satisfaction with the PLSs and valued the opportunity to discuss their experiences and receive brief education about the topic.

A few limitations should also be noted. First, attendance at most PLSs was only open to members of four partnered organizations, which may limit generalizability. Second, demographic information beyond the eligibility criteria was not collected. Third, based on attendee survey feedback, the PLSs were refined iteratively between sessions, and moderators changed in response to attendee feedback. Moreover, one

PLS added the opportunity for continued online dialogue for a week after the PLS. While this responsiveness reflects community-engaged practice, it may have influenced the dynamics of discussion and ability to compare content themes across sessions. Last, the analysis was conducted by a single analyst, which prioritizes interpretive depth but may shape theme identification through the analyst's perspective.

Conclusions

Overall, the WomenWise PLSs generated actionable, patient-centered research priorities in an area where women remain underrepresented. Attendees described significant unmet needs in AUD diagnosis and treatment, and offered recommendations to improve future studies. These insights call for tailored, culturally-sensitive, and context-responsive treatment and research rather than one-size-fits-all approaches. This project identified CER priorities that are grounded in the realities and voices of women community members and healthcare providers with lived experiences. Next steps are to design studies to address these priorities and continue engaging with communities to co-design women-centered approaches to AUD treatment and care delivery.

Declarations

Ethics approval and consent to participate

This project was submitted to the Mayo Clinic Institutional Review Board which determined that the project was not human subjects research and was exempt from review and obtaining informed consent (IRB: 24-004906). Because this project was deemed "not human subjects research", it was exempt from guidelines and regulations such as the Declaration of Helsinki.

Competing interests

The authors declare that they have no competing interests.

Consent for Publication

Not applicable

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Author Contribution

BT: Investigation, Writing-original draft; AM: Investigation, Writing-original draft; CS: Formal analysis, Writing-review & editing; TV: Writing-review & editing; TT: Writing-review & editing; MS: Writing-review & editing; CS: Writing-review & editing; PV: Writing-review & editing; CY: Writing-review & editing; KB: Conceptualization, Writing-review & editing; AC: Conceptualization, Writing-review & editing; CP: Conceptualization, Funding acquisition, Methodology, Supervision, Writing-review & editing; PS: Conceptualization, Funding acquisition, Methodology, Investigation, Supervision, Writing-review & editing.

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Data Availability

The data generated and analyzed during the current project are available from the corresponding author on reasonable request.

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Tables

Table 1
PLS Attendee Details

Partnered organization	Date	Moderators, co-hosts, and attendees	Attendee states/provinces of residence
National Network of Depression Centers	May 8, 2025	- 1 moderator (PS) - 1 co-host - 7 attendees	Illinois, Maryland, Michigan, New York, Ohio, Ontario, Pennsylvania
Wisconsin Women's Health Foundation	June 19, 2025	- 2 moderators (PS, BT) - 1 co-host - 7 attendees	Wisconsin
National Grange/Rural Minds	July 14, 2025	- 3 moderators (BT, AM, PS) - 2 co-hosts - 9 attendees	Hawaii, Illinois, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Washington D.C.
Mayo Clinic Connect	September 16, 2025	- 2 moderators (BT, AM) - 1 co-host - 13 attendees	California, Illinois, Florida, Michigan, Minnesota, Missouri, Nebraska, North Carolina, Ontario, Oregon
Healthcare providers specializing in AUD treatment	November 20, 2025	- 2 moderators (BT, AM) - 15 attendees	Minnesota, Wisconsin

Table 2
PLS Thematic Domains with Additional Quotes

Content Domains	Themes	Illustrative Quotes
Shame and stigma unique to women	• Gendered norms, “mom culture,” and double standards • Stigma, shame, and “quiet drinking” • Caregiving role strain, identity, and “superwoman” expectations	“[People say] They should drink more ladylike. Keep it together and not be messy.” (HCP6) “As moms, even if you do go out with your friends, you’re still expected to come home and be able to attend to the kids.... It’s not okay to just come home and pass out.” (HCP7) “When I was in undergrad...they made us screen for AUD every time I went to the doctor, but I lied on every survey I ever took.” (NNDC5)
Barriers to Treatment for Women	• Structural barriers to treatment access • Provider training gaps and missed clinical opportunities • What “good communication” looks like • Actionable linkage to care • Trauma, mental health comorbidity, and whole-person care • Privacy, confidentiality, and fear of records/visibility	“My daughter is still in treatment... Her husband went through treatment by going to jail. I think that probably happens to men a little more often than women.” (MCC7) I once had a doctor...say, “You can’t be an alcoholic until you’re 21. It’s not legal for you to drink.” (NNDC5) “Since it’s a rural hospital and most everyone knows everyone, if you happen to come to the ER and ask for the inpatient drug and alcohol treatment, you may be neighbors or family members of some of the nurses or other staff that are there. I think people shy away from asking for that help...because someone might find out.” (NGRM7) I spend hours a day reading charts... [When] providers talk about substance use, it’s literally, “Just say no.”... Or “Just cut back.” (HCP2) When a PCP determines that their patient uses and abuses alcohol, then a...discussion should proceed with a Motivational Interviewing approach and should be non-confrontational. (MCC5)
Future research priorities	• Research participation: trust, burden, representation, transparency • Tailoring research to women’s needs	It shouldn’t be about...come and be my guinea pig.... It should be about the long-term effects. (WWHF2) I think that we need to...do it ourselves as a community... of women to look at the defundin’ of programs...that could help us, and do it on our own like we’ve had to do for generations and generations. (MCC5)
Abbreviations for each PLS session: HCP = healthcare provider PLS; NNDC = National Network of Depression Centers; MCC = Mayo Clinic Connect; NGRM = National Grange/Rural Minds; WWHF = Wisconsin Women’s Health Foundation		

Table 3
Future CER Topics Suggested in Partnered Learning Sessions

Topic	Potential CER trial
Medication treatment vs. psychotherapy	Examine comparative effectiveness among women.
Trauma-focused care vs. standard AUD treatment	Examine comparative effectiveness among women.
Family or couples' treatment vs. individual-only	Examine comparative effectiveness among women.
Harm reduction/moderation vs. abstinence-only	Compare harm reduction to abstinence-only treatment specifically in women.
Care access and engagement: remote support + proactive navigation	Examine effectiveness for women with AUD facing access barriers.
Identity-concordant vs. open-access groups	Stratify by identity to compare effectiveness with mixed-identity groups.
Note: CER = comparative effectiveness research; AUD = Alcohol Use Disorder. Topics and trial framings were generated by PLS attendees, drawing on their personal or professional experience, after didactic education on the PICOTS (Population, Intervention, Comparator, Outcome, Timing, Setting) framework for comparative effectiveness research.	

Figures

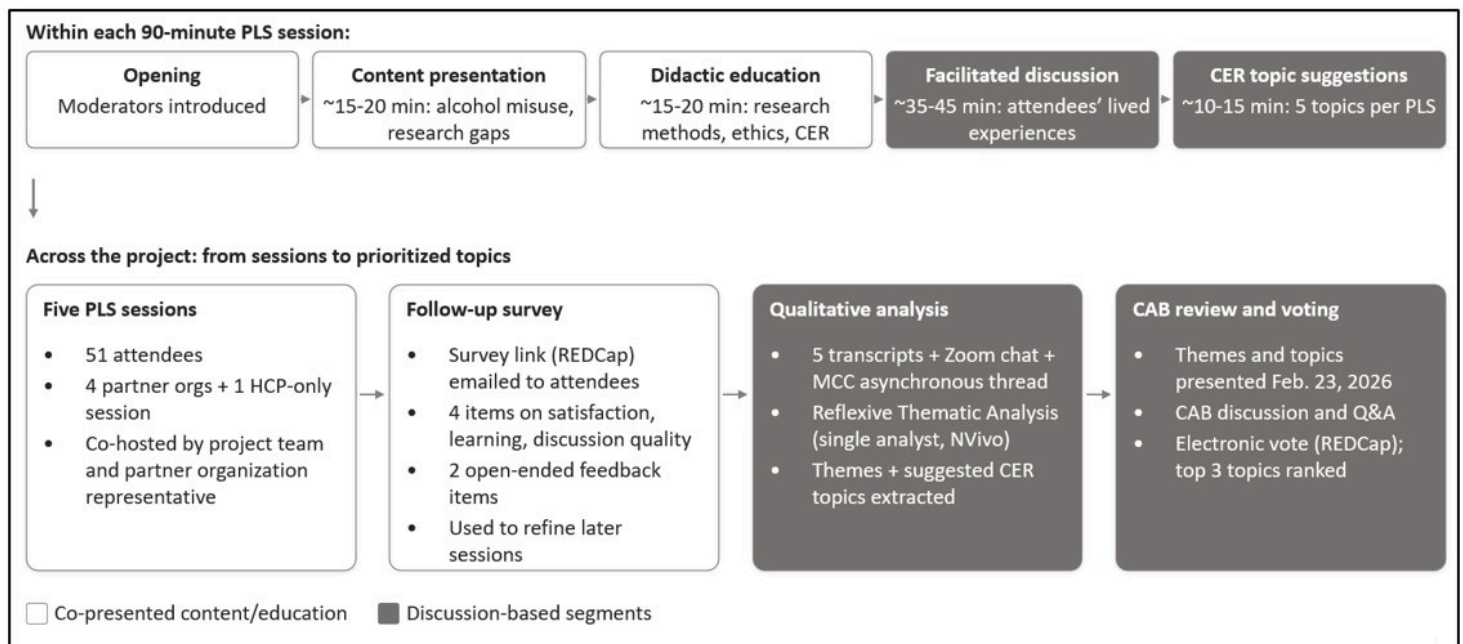


Figure 1

From the Partnered Learning Session to Prioritized CER Topics.

Legend: Flow diagram showing PLS format and process of selecting prioritized research topics.
Abbreviations: CER = comparative effectiveness research; HCP = healthcare provider; MCC = Mayo Clinic Connect; CAB = Community Advisory Board.

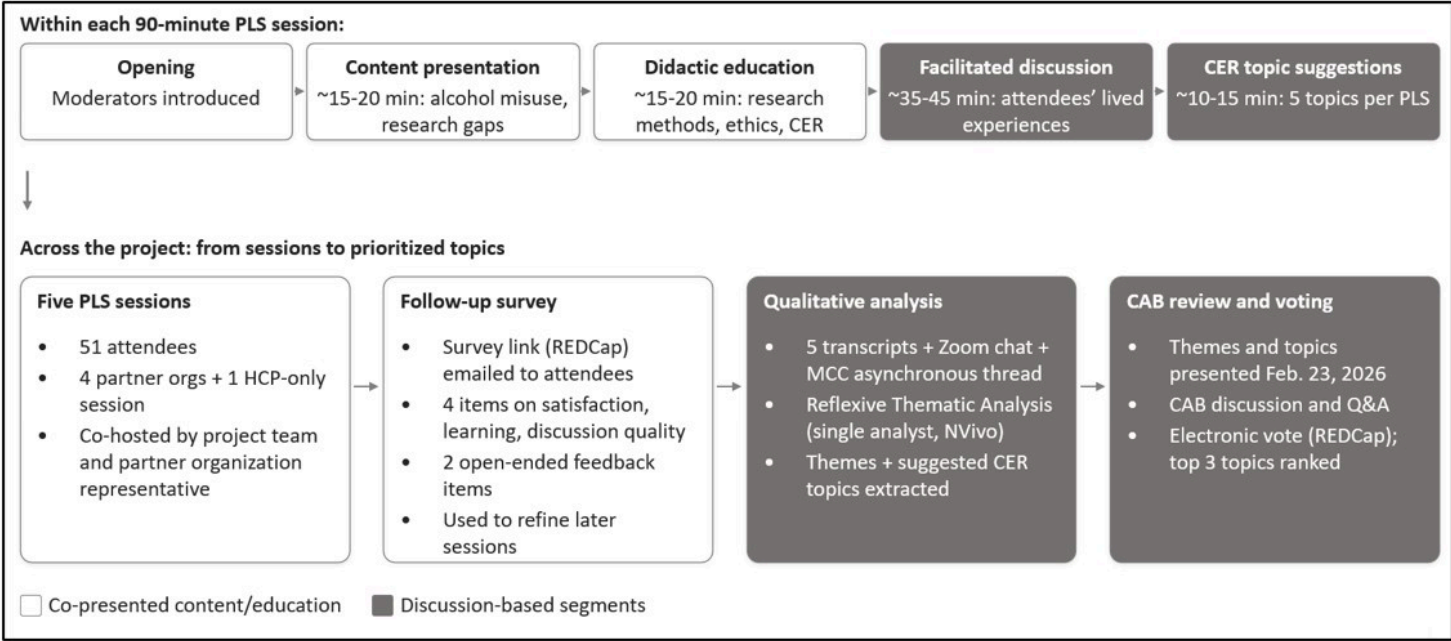


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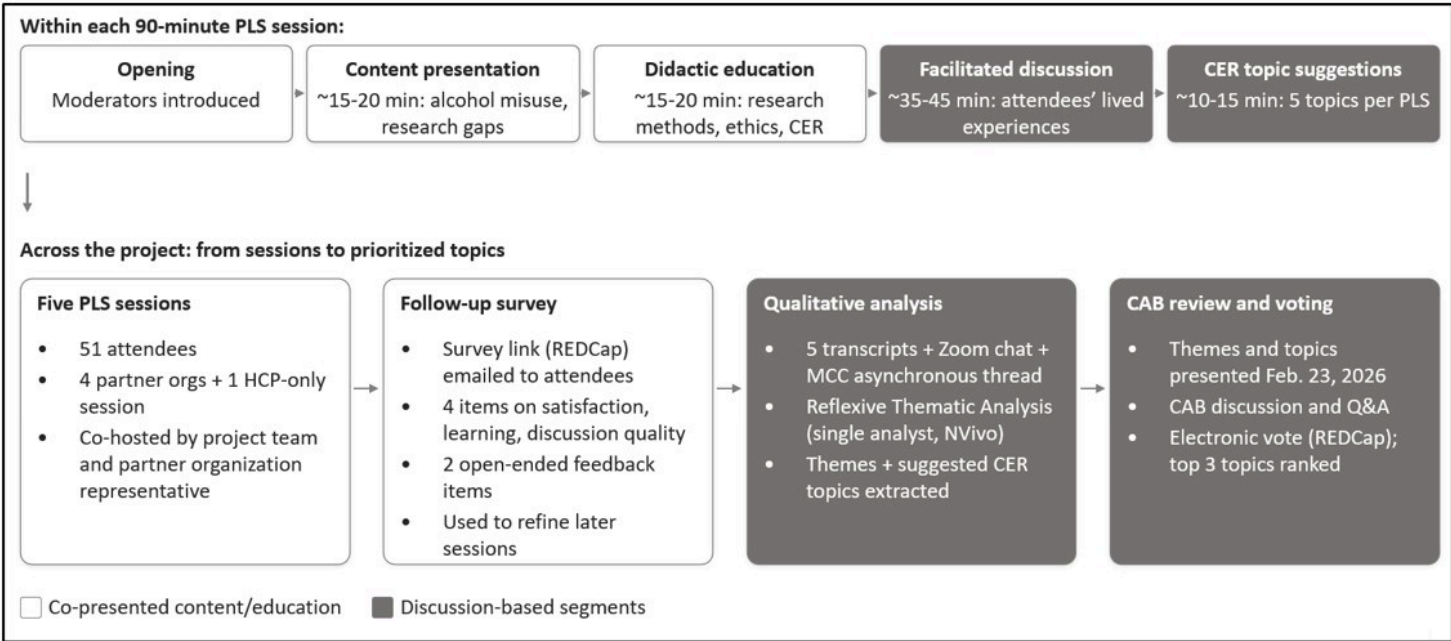


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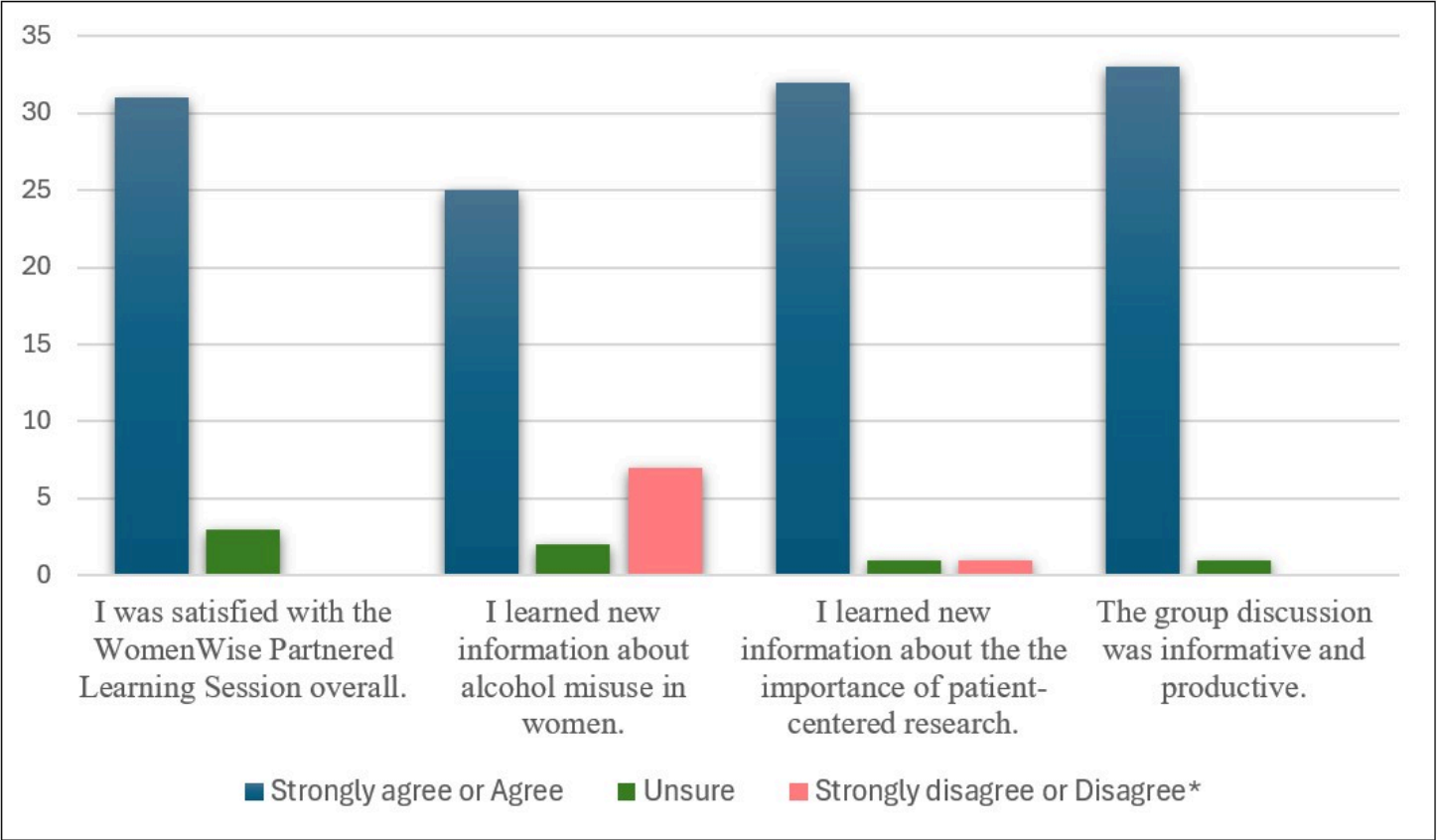


Figure 2

WomenWise PLS Follow-Up Survey Responses (n=34)

Legend: Responses to Likert-scale questions on the WomenWise PLS follow-up survey.

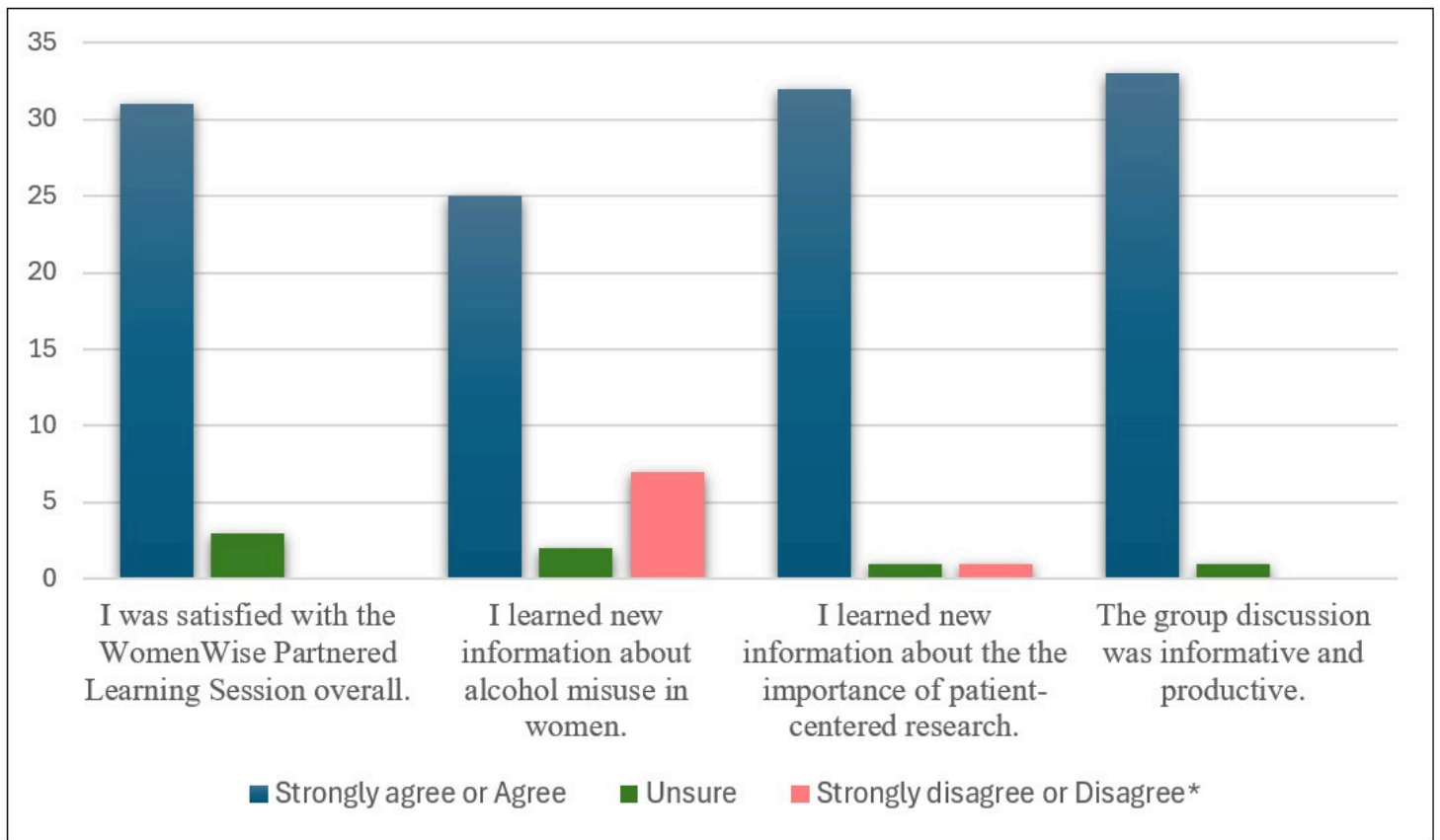


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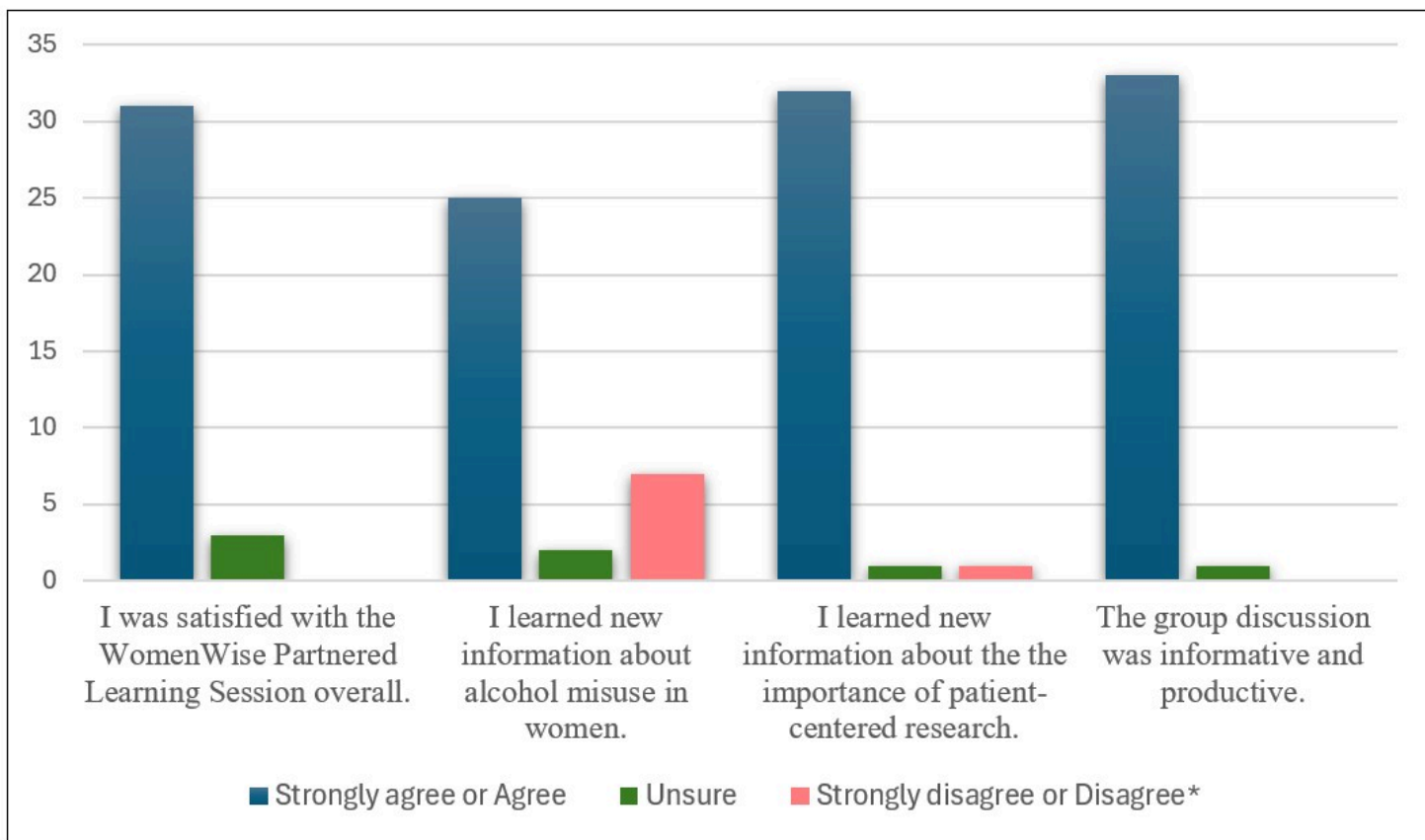


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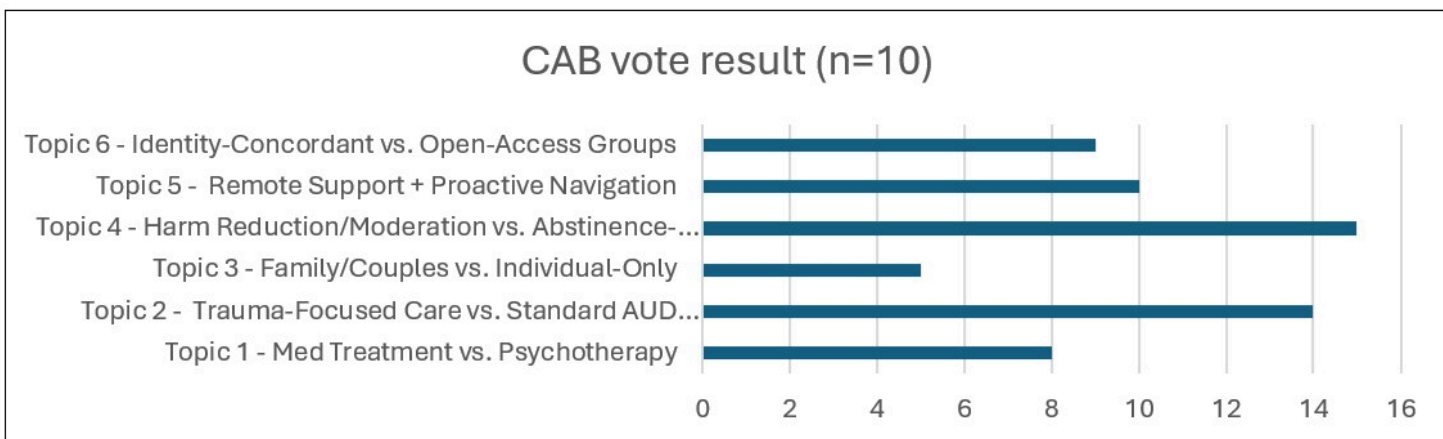


Figure 3

WomenWise CAB Priority Topics Vote Result

Legend: Votes were ranked by weighted score to reflect priority.

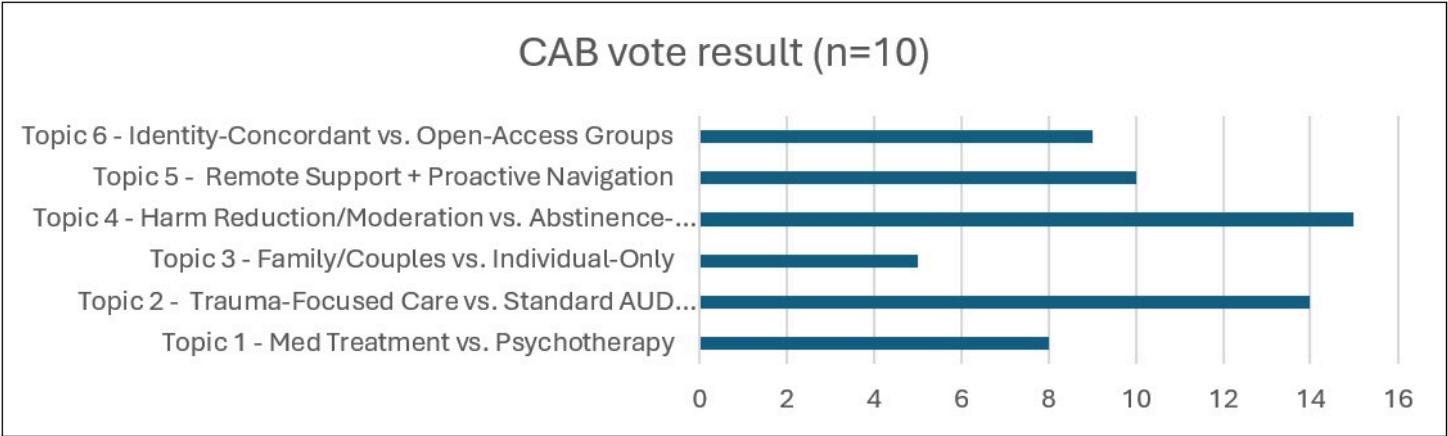


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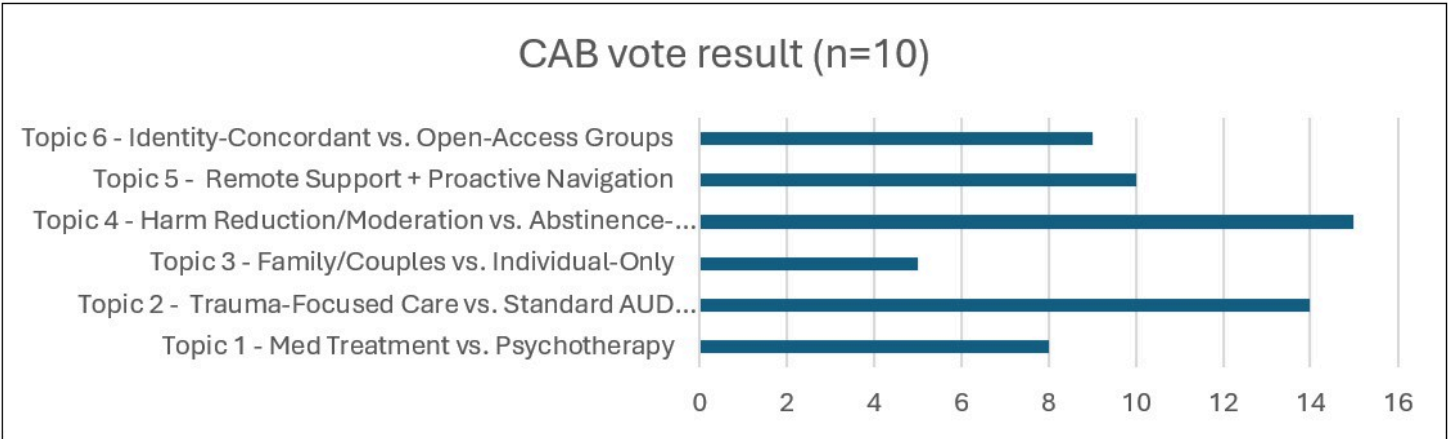


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WomenWise CAB Priority Topics Vote Result

Legend: Votes were ranked by weighted score to reflect priority.

Supplementary Files

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