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Mechanisms and processes involved in women's pathways into alcohol dependence and towards recovery: a qualitative meta-synthesis

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Abstract

Women's heavy drinking is often rooted in trauma and histories of abuse, while socio-cultural factors affect both the initiation of use as well as pathways to recovery. Research has largely focused on the epidemiology of alcohol use, and considerably fewer studies have examined the elements that facilitate recovery and the socio-cultural specificities that affect women's lives. To address this gap, we conducted a qualitative meta-synthesis in which we employed a holistic approach to exploring women's pathways into alcohol dependence and towards recovery. Twenty-three qualitative studies from 1998 to 2018 were identified from relevant databases and synthesized to delineate the mechanisms that led to dependence and how these affected recovery processes. Results highlight the complex interplay between adverse childhood experiences, sense of 'self', and wider dynamics of power. Alcohol was initially used as a corrective agent and as a tool of temporary empowerment, regulating structural and familial imbalances. However, drinking became progressively compulsive and overpowered every aspect of life. Initiation of recovery was often hindered by shame and stigma and facilitated by belonging to and being accepted by recovery groups and a revision of 'the self' within wider social structures. Implications for treatment, policy, and practice are discussed.

Keywords: process, alcohol recovery, qualitative, review

Main text

Introduction

Research to date highlights the differential gender effects of alcohol, physically, psychologically, and socially (Van de Walde et al., 2002). While men are more likely to be heavy, more frequent drinkers and experience alcohol-related problems, women are reported to have a tendency for binge drinking (Plant, 2008; Chaiyasong et al., 2018). However, the rates of alcohol use and 'alcohol use disorder' among women are increasing (Slade et al., 2016; Grant et al., 2017; Grucza et al., 2018), in some cases at a higher rate than men (Grant et al., 2017).

Gender differences are not just documented in prevalence rates; several studies report differences in alcohol's biological and pharmacological effects in men and women (Lancaster, 1994; Thomason, 2002; Wasilow-Mueller and Erickson, 2001; Brady and Ashley, 2005; Nolen-Hoeksema, 2006). Alcohol-related mortality rates are higher for women (Jarque-Lopez et al., 2001, van de Walde et al., 2002, Guitart et al., 2015), while physical effects and health consequences are experienced more rapidly (van de Walde et al., 2002; Mann et al., 2005) and severely (Ceylan-Isik, McBride and Ren, 2010). Prevalence of comorbid psychiatric disorders is also higher in women than men who meet the diagnostic criteria for alcohol dependence (Brown et al., 2000; Van de Walde et al., 2002).

Generally, women tend to develop drinking problems as a result of stress or trauma (Allan and Cooke, 1985). Sexual and/or physical abuse, whether in childhood or from a spouse, are widely reported precursors of alcohol dependence in women (Duncan, Walz and Yep, 2005; Kruk and Sandberg, 2013), as this population group often uses alcohol as a way to self-medicate the

emotional trauma of sexual assault, abuse and violent attacks (; Brienza and Stein, 2002; Miranda et al., 2002; Brady and Ashley, 2005; Covington, 2008).

In addition to the distinct biological and psychological effects of alcohol among men and women, considerably strong socio-cultural factors affect the views and development of alcohol dependence in women and impact diagnosis, treatment, and their overall recovery pathways (Sanders, 2018). The inherent differences derive from traditional stereotypical views of women and how these influence the social construction of gender roles. The 'alcoholic woman' is often perceived as deviating from the traditionally assigned roles of caring for others and having specific traits and characteristics such as kind and sensitive (Eagly, Wood and Diekman, 2000). Deviating from the assigned societal expectations and roles that are different from those assigned to men often threatens women's social status and reinforces experienced stigma and discrimination (Sanders, 2018). Media representations tend to associate drinking with deviance, sexual promiscuity, uncontrollable sexual behaviors, and prostitution (Van der Walde, 2002), reproducing perceptions of addiction as a matter of individual pathology isolated from structural factors that have shaped women's lives.

Qualitative studies on gender and alcohol use have focused extensively on gender norms, emphasizing women's agency (Ettore, 1992; Measham, 2002), positioning women's drug and alcohol use as central in constructing gendered identities. Gender norms and societal expectations often result in stigmatization when the 'alcoholic woman' deviates or is unable to fulfil prescribed gender roles (i.e., wife, mother). The pressures of being a mother, the stress of conforming to societal expectations and norms, the breakup of the marriage/family, empty nest syndrome have all been reported as precursors of heavy drinking (Beckman,1994). Workplace gender prejudice, more specifically, harassment from males, is also listed as a factor contributing

to drinking (Goldberg, 1995; Brady and Randall, 1999), often leading to the experiences of self-punishment and shame by women t (Sanders, 2018). Shame can further reinforce the drinking behaviors and contribute to the development of dependence, especially given that women tend to define themselves in relation to others (Culp and Beach, 1998).

Women's drinking is highly influenced by peers or significant others (Hughes and Wilsnack, 1994; Lex 1994), with women often drinking to gain a sense of connection. However, the social stigma and consequent shame and guilt from heavy drinking increase the sense of isolation, loneliness, and disconnection (Van de Walde et al., 2002), creating a cycle where women will then drink in response to further negative views of themselves and experienced losses (Goldberg, 1995). The stigma and cultural bias against heavily drinking women is seen as incompatible with conventional gender norms that negatively affect women's social image and relationships within the family, as well as their ability to perform assigned gender roles (van de Walde et al., 2002; Wilsnack and Wilsnack, 2002). These further lead to the internalization of shame (Sanders, 2010, 2014) and act as a significant hindrance in detecting, disclosing, and treating alcohol dependence (Hettinger, 2000; van de Walde et al., 2002; Wilsnack and Wilsnack, 2002).

Compared to men, women face significant barriers to treatment that might differ from men, such as childcare, experiences of victimization and domestic violence, financial difficulties, trauma, unemployment, and risks of losing child custody (Greenfield et al., 2010; Krentzman et al., 2012). Limited research in substance use treatment indicates that addressing differential needs and offering gender-specific services, such as incorporating childcare, can improve outcomes (Brady and Ashley, 2005). The examination of these factors, as well as gender differences in recovery from alcohol dependence, specifically have received less attention (McCaul et al., 2019). Literature so far has largely focused on the epidemiology of alcohol use, risk factors, and

effects of alcohol on women. Considerably fewer studies have examined the elements that facilitate recovery, taking into account the socio-cultural specificities that affect women's lives (Krentzman et al., 2012). Moreover, it has been noted that mainstream addiction treatment services tailor their provision to men and often overlook women's needs (Covington, 2008; Salter and Breckenridge, 2014).

Recovery can be described as 'a lived experience of improved life quality and a sense of empowerment' (Best and Laudet, 2010, p. 2). This experience is illustrated as a long-term, gradual personal process (Laudet, 2008; Kougiali et al., 2017) that involves changes in several life domains (Best et al., 2011; Dekkers, De Ruysscher and Vanderplasschen, 2020). It can occur in various ways that extend beyond abstinence and depend on contextual factors and available resources (Kaskutas et al., 2014). The multitude of factors involved in recovery trajectories highlights the need to examine processes, an area which has traditionally received less attention than outcome-focused, pre-post studies that examine intervention effectiveness at specific points of complex recovery pathways (Kougiali et al., 2017).

The need for a more specific understanding of women's recovery pathways that go beyond cognitive-behavioral and biological models of addiction has been well argued in previous literature (Van der Walde et al., 2002; Roseribloom, Pfefferbaum and Sullivan, 2004; Krentzman et al., 2012). Recent work on recovery capital (RC) is based on Cloud & Grandfield's (2008) influential conceptual framing and identification of components of internal and external resources (social, physical, human and cultural) that constitute the "sum of resources necessary to initiate and sustain recovery from substance misuse" (Best and Laudet, 2010). Structural differences in the resources available to different populations have been acknowledged in the literature, indicating that women can have lower levels of human capital

and experience cultural capital differently to men via oppressive experiences of social control (Wincup, 2016). Although primarily focusing on drug-using populations, work on this area highlights the significantly restricted focus on women's recovery experiences, leading to the lack of understanding of RC and the resources that might be conducive to positive recovery outcomes (Hennessy, 2017).

This study aims to synthesize the available qualitative literature on women's recovery from alcohol dependence. Specifically, qualitative studies on the topic can offer an insight into the dynamic interplay of personal and contextual factors that affect women's pathways into and out of alcohol dependence. To the authors' knowledge, this is the first systematic attempt to synthesize the available qualitative literature on the process of women's lifelong pathways into dependence and towards recovery from alcohol. It is expected to offer valuable knowledge towards understanding the different needs, mechanisms, and factors that can facilitate or hinder women's recovery.

Method

Design

A meta-synthetic methodology was employed following Noblit and Hare's (1988) meta-ethnographic approach, a method which is applicable to qualitative work beyond ethnography (Britten et al. 2002; Campbell et al. 2003). Meta-syntheses allow for the development of third-order theories and constructs that go beyond the sum of findings (meta-summary) to the interpretive integration and syntheses of data derived from all of the across reviewed articles (Thorne et al., 2004).

Search strategy

The following electronic databases were searched for English-language peer-reviewed articles published over the range of 20 years (1998-2018) via EBSCOhost - Academic Search Complete; Academic Search Ultimate; CINAHL; Criminal Justice Abstracts; MEDLINE; PsycArticles; Psychological and Behavioural Sciences; PsycINFO; SocIndex; and Google Scholar. Searches were made using the keywords, which were filtered by qualitative methodology:

Alcoholism OR alcoholic OR alcohol addiction OR alcohol dependency

AND recovery OR sobriety OR abstinence OR sober

AND mechanism OR process

OR experiences OR views OR attitudes

AND women OR woman OR female OR females.

ZK conducted the search twice, which was also run separately by AP and an independent researcher

The review has been registered at Prospero (Prospero ID: CRD42018110465, registered 22 November 2018).

Screening and eligibility

The inclusion criteria were restricted to qualitative studies focusing on adult women aged 18 years and older, whose primary substance of concern was alcohol. Abstracts were screened independently by ZK and AP, and any disagreements were discussed and resolved after the end

of the screening. Gender- and substance-blind studies or studies that did not specify the primary substance of focus were excluded. Further reasons for exclusion involved the analysis of historical data, creative representations of data that altered participants' original accounts, and clinical notes that did not include any data or analysis (see Figure 1 for details of searches and screening stages). The final number of studies included in this review is 23.

(Fig. 1-Prisma - here).

Study and sample characteristics

The 23 studies included in this review (see Table 1 for an overview) include the accounts of 390 women. Sanders (2006) and Sanders (2010) analyze data from the same dataset, similar to the studies of Jacobs and Jacobs (2014) and Jacobs, Naidoo and Reddy (2012). The majority of the studies were conducted in the US (15), and fewer in other countries such as the UK (2), South Africa (2 involving the same sample), Thailand (1), Canada (1), Sweden (1), Scotland (1). Recruitment took place primarily in AA (13), combined AA and non AA approaches (4), a women's support group (1), a women's day center (1), a psychiatric outpatient setting (1), and a treatment center where no specific approach was mentioned (1). Two studies did not specify the setting.

(Table 1 here)

Methodological Quality assessment

A methodological quality assessment was conducted to obtain an overview of the reviewed articles' analytical and methodological quality, which would further inform any consequent action, such as excluding specific studies. Although the analytical and methodological quality varied, all the articles scored above average, and no study was excluded. The scoring was conducted independently by ZK and an independent researcher, using criteria based on the Critical Appraisal Skills Programme (CASP) (the full proforma is available from the corresponding author). Individual rating scores were discussed within the team, and where consensus was not reached, a third reviewer was asked to score independently.

Data extraction and Analysis

A meta-synthetic approach shares epistemological commonalities with that of critical realism and interpretivism. By comparing, contrasting, and synthesizing a larger number of studies, the method's main strength lies in that it allows the exploration of an underlying reality not apparent when examining individual studies alone (Heyman, 2009). As such, the current meta-synthesis does not aim to provide a single explanation or truth but instead reflects on the accounts and personal constructions of women's experiences as shaped by personal and contextual factors, which influence their drinking and recovery pathways.

Following the iterative research process previously used by Noblit and Hare (1998), the following steps were applied: 1) identification of the specific area of study, 2) determining which research studies fulfill the inclusion criteria and relevance, 3) reading the studies to determine potential themes, 4) determining how studies are related, 5) translating/comparing studies/themes with each other, 6) synthesizing these translations/findings and 7) expressing and reporting these findings.

Coding of the data was initially conducted independently by all three researchers and later compared, discussed, and reflected upon within the research group. We conducted a thematic analysis, assisted by the use of Nvivo 11 software. The analytical process involved a reciprocal translation that went beyond first-order accounts of participants and second-order interpretation of articles' authors and produced third-order constructs that exceeded the collection and summation of common themes across the studies. Both participants' quotes and authors' interpretations were examined and synthesized with a particular focus on mechanisms and processes of addiction and recovery within their particular relational, spatial, and temporal contexts.

Results

Theme 1: Pre-drinking' self'

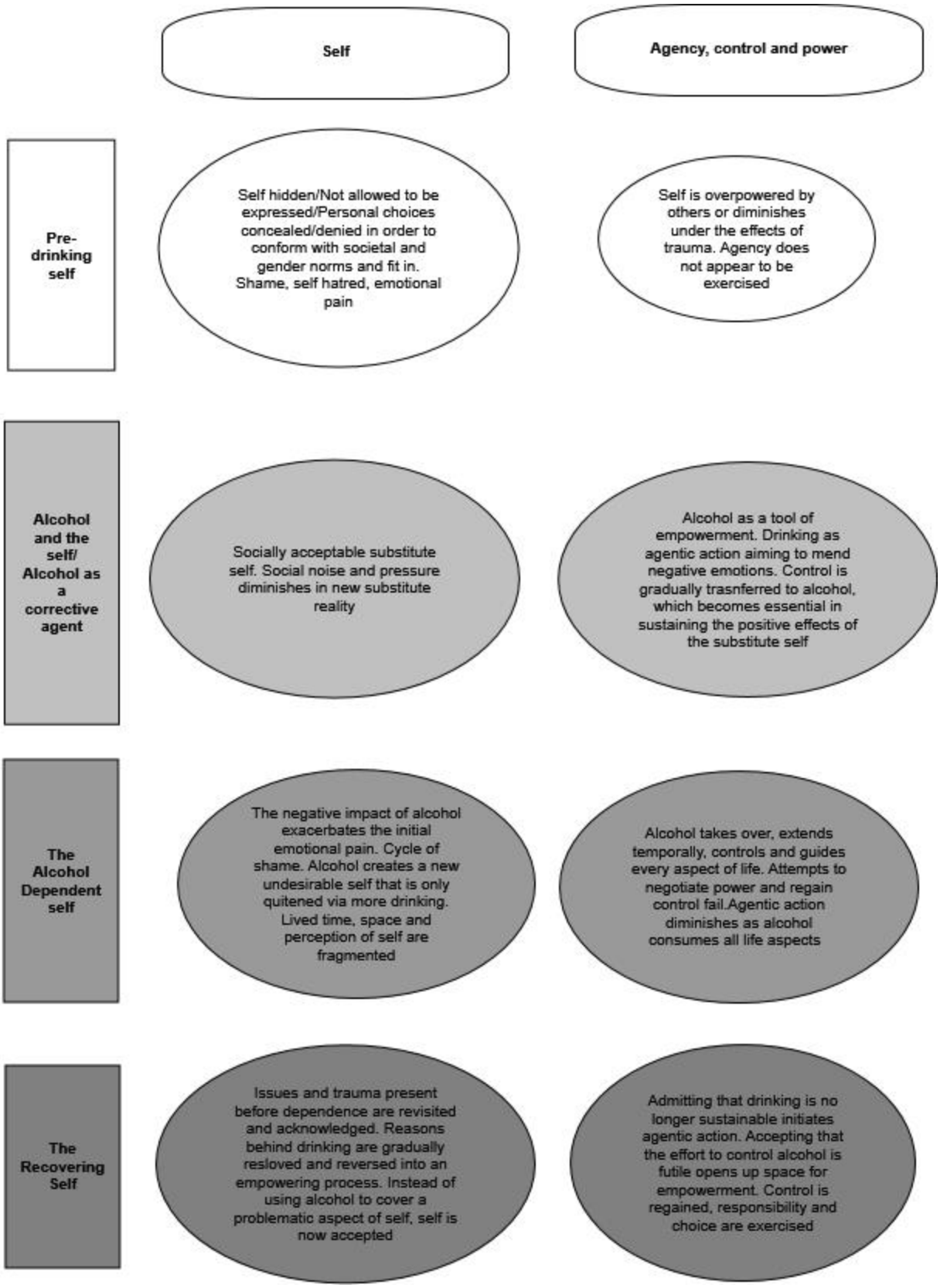
Trauma and (poly) victimization

A significant number of women's retrospective accounts revealed adverse childhood experiences as a precursor and a perceived causal factor of alcohol dependence later in life. Specifically, women revealed experiences of childhood sexual abuse (Boyd and Mackey, 2000; Hood, 2003; Brewer, 2006; Pettinato, 2008), growing up in abusive families (Boyd and Mackey, 2000), with emotionally or physically absent parents all of which often led to feelings of abandonment, lack of belonging and rejection (Lillie, 2002; Prussing, 2007). In Pettinato's (2008) study, 10 out of 13 women reported coming from families where one of the parents was described as 'alcoholic.' As adults, some women reported a continuation of traumatic experiences through their involvement in abusive relationships, as partners of alcohol-dependent or abusive men (Boyd

and Mackey, 2000; Hanpatchaiyakul et al., 2017), often adopting the belief that abuse was inherent to and a natural element of relationships, a result of 'not being worthy of anything better' and a preferable option to loneliness (Sobczak, 2009).

Women reported intense feelings of shame and hopelessness associated with past early childhood traumatic experiences, ranging from abuse to dysfunctional familial practices and poly victimization later on in life. These events had defined their self-perception as well as the way they felt others perceived them. Participants across studies described feelings of inadequacy, not belonging, a deep sense of inferiority (Boyd and Mackey, 2000; Hanpatchaiyakul et al., 2017), negative self-images (Boyd and Mackey, 2000; Hood, 2003), anger for past victimization (Brewer, 2006) and internalized shame that had not been dealt with (Boyd and Mackey, 2000; Brewer, 2006; Pettinato, 2008; Hanpatchaiyakul et al., 2017; Doty-Sweetnam and Morrissette, 2018;). Many reported having no self-esteem, self-worth, purpose in life (Boyd and Mackey, 2000), or identity (Pettinato, 2008), while one woman reported that 'I wasn't a person. I didn't exist as a person (Hood, 2003)'. These early experiences had shaped women's beliefs of being deeply flawed and unlovable, which was expressed in attempts to hide their 'real self' (Hood, 2003; Doty-Sweetnam and Morrissette, 2018), while feelings of self-loathing fueled efforts to disconnect from what they felt was their true identity (Pettinato, 2008).

(Figure 2 here)


Self
Agency, control and power
Pre-drinking self
Self hidden/Not allowed to be expressed/Personal choices concealed/denied in order to conform with societal and gender norms and fit in. Shame, self hatred, emotional pain
Self is overpowered by others or diminishes under the effects of trauma. Agency does not appear to be exercised
Alcohol and the self/ Alcohol as a corrective agent
Socially acceptable substitute self. Social noise and pressure diminishes in new substitute reality
Alcohol as a tool of empowerment. Drinking as agentic action aiming to mend negative emotions. Control is gradually trasnferred to alcohol, which becomes essential in sustaining the positive effects of the substitute self
The Alcohol Dependent self
The negative impact of alcohol exacerbates the initial emotional pain. Cycle of shame. Alcohol creates a new undesirable self that is only quitened via more drinking. Lived time, space and perception of self are fragmented
Alcohol takes over, extends temporally, controls and guides every aspect of life. Attempts to negotiate power and regain control fail.Agentic action diminishes as alcohol consumes all life aspects
The Recovering Self
Issues and trauma present before dependence are revisited and acknowledged. Reasons behind drinking are gradually resloved and reversed into an empowering process. Instead of using alcohol to cover a problematic aspect of self, self is now accepted
Admitting that drinking is no longer sustainable initiates agentic action. Accepting that the effort to control alcohol is futile opens up space for empowerment. Control is regained, responsibility and choice are exercised

Gender norms and predefined gender roles

Regardless of adverse childhood experiences, gender norms and predefined traditional roles were a constant factor in women's drinking pathways and were described as a contributory factor towards the initiation of drinking, as a form of pressure that facilitated continuation, as well as a barrier to disclosing problematic use and accessing treatment.

Faced with expectations of what women's roles and pathways were predetermined to be in familial settings, participants reported with consistency that their real 'self' was perceived as not being allowed to emerge. Alcohol appeared to play a significant role in either keeping socially undesirable parts hidden or assisting in presenting an alternative, socially acceptable personality. As described by the participants, women's pathways were predefined in the life choices they could make, and, similarly, their identity repertoire was restricted in what was socially and culturally acceptable. Some had grown up in strictly religious families who would not allow their authentic 'self' to emerge (Pettinato, 2008; Shinebourne and Smith, 2009), while, as adults, women reported that they got married either to fulfill family expectations or because their partner chose to (Paris and Bradley, 2001; Pettinato, 2008). Some women followed a predefined yet not fulfilling or chosen life path (Paris and Bradley, 2001) and often assumed responsibility for having failed assigned roles as a wife when marriage problems occurred (Hanpatchaiyakul et al., 2017). Participants in Hood (2003) identified that a significant reason behind women's mental health and addiction issues was a larger societal problem that assumed that women's role is expected to be restricted to supportive, nurturing, and caring duties, while they learn to prioritize others' needs over their own, which tend to be evaluated as less important or not worthwhile.

Pettinato (2008) explores the experiences of lesbian women with alcohol problems. Participants reported lifelong difficulties with allowing their 'real self' to be expressed, with several attempts from an early age to contain their preferences and behave within the expected gender norms. Especially those who grew up in religious families, whereby homosexuality was confronted, they were met with a struggle between renouncing their lesbian identity or denying religious traditions and family expectations. For some women, the knowledge that the Bible condemns such relationships led to self-loathing. Women described a deterioration in mental health, suicidal attempts, and alcohol use to disconnect from reality, tolerate heterosexual physical contact, and often proceed to marriage to fulfill social expectations.

Theme 2. Alcohol as a corrective agent

Participants described experiencing disconnectedness and a sense of fragmented 'self' while alcohol was used as a way to correct such feelings temporarily. . Specifically, women reported that alcohol was the means of dealing with emotional pain, anger, and feelings of being flawed stemming from past trauma after experiences of abuse (Hood, 2003; Brewer, 2006; Doty-Sweetnam and Morrissette, 2018). Feelings of inadequacy, lack of self-esteem, self-loathing and anxiety (Lillie, 2002; Hood, 2003; Mackie, 2008; Pettinato, 2008), emotional pain that stemmed from past dysfunctional familial practices, abandonment and coping with alcoholic parents (Pettinato, 2008) as well as dealing with current familial pressures and drinking partners (Jacobs and Jacobs, 2014).

Alcohol functions

The analysis revealed that alcohol functioned in three ways in relation to women's lives, their sense of 'self' and identity:

1) Substitute 'self': alcohol assisted in creating an alternative, socially acceptable 'self' and helped conceal personality characteristics that were considered undesirable.

2) Substitute reality: alcohol disrupted temporal reality, and drinking was performed as a way to retreat from experiencing life consciously.

3) Temporary empowerment: feelings of powerlessness preceded alcohol dependence; drinking allowed for temporary empowerment and reclaiming control.

1. Substitute 'self':

Women described the ways alcohol helped freeze the experienced emotional pain and assisted towards the presentation of a substitute 'self' who was socially accepted, avoided judgment and negative social responses (Lillie, 2002; Mackie, 2008; Shinebourne and Smith, 2009), encouraged positive attention (Hood, 2003), helped hide feelings of inadequacy and inner turmoil (Paris and Bradley, 2001; Lillie, 2002; Pettinato, 2008; Jacobs et al., 2012) and prevented from appearing flawed or fragmented to others (Gee et al., 2017).

Participants in Hood's (2003) work described how drinking brought a sense of normality stemming from the ability to present a socially accepted, albeit a different version of the self:

But the reason I drank in the first place was no self-esteem whatsoever. And just feeling totally insecure and so totally full of hate that it is just painful to be around people unless I could

change how I felt about myself or change how I was. Because for a while, I had an excuse to laugh, tell a joke, and the excuse was alcohol, you know. It helped change me, my whole personality. But it's not even low self-esteem, it's NO self-esteem. That's why I drank. I wasn't a person. I didn't exist as a person. And I ' II tell you it's like when I had the drink, I can be whoever I want now. Which is all a total illusion, but I really believed it for(..)you know when it worked for a while. (Abby as cited in Hood, 2003, pg. 62)

2. Substitute reality

Alcohol was used as a way to disconnect and disassociate from reality (Pettinato, 2008, Nehlin, Fredrikson and Oster, 2013), avoid acknowledging events that were linked to traumatic pasts (Pettinato, 2008), endure sexual relationships, and avoid remembering details of physical abuse (Jacobs and Jacobs, 2014; Sobczak, 2009; Hanpatchaiyakul et al., 2017). Some women resorted to alcohol to cope with the pressures of raising children as single mothers (Jacobs and Jacobs, 2014; Jacobs et al., 2012) and those imposed by societal expectations to follow unfulfilling life choices, such as marriage (Paris and Bradley, 2001; Pettinato, 2008). Pettinato (2008) describes the way women used alcohol to disassociate from lives constructed around predefined societal roles and gender norms, whereby alcohol assisted in the distress arising from suppressing parts of 'the self':

...push back the fact that I was gay. I was gonna go on my life and be straight. And so I did, and I drank throughout (...). I married, this is what you're supposed to do ... oh, I drank and drank and drank. we're having sex on a regular basis because that's what you do when you're married and I'm not enjoying this one bit at all . . . I'm a lesbian, I'm with a man, this is not working and probably a year into the marriage it starts to get really evident..(pg. 626)

Sexual or physical abuse had a significant role in women's drinking pathways. Alcohol served as a way to escape and relieve emotional pain originating in traumatic memories, but also as a way to disconnect from a reality where abuse was taking place (Hood, 2003; Pettinato, 2008; Sobczak, 2009; Jacobs and& Jacobs, 2014; Hanpatchaiyakul et al., 2017). Drinking offered women the ability to detach themselves from intimacy and tolerate sexual relationships without being conscious and emotionally present (Pettinato, 2008; Sobczak, 2009). Some participants reported that alcohol served as a tool to fortify themselves against active abuse or help them endure abusive partners. For example, an interviewee in (Sobczak (2009) recalls, *"Knowing that he was gonna be either physically abusive or emotionally abusive, I would start drinking about 30 minutes before he came home from work to fortify myself."* In these cases, drinking towards a blackout state helped avoid experiencing reality fully (Pettinato, 2008) and facilitated the transition towards one where women were not sober enough to acknowledge (Pettinato, 2008).

3. Temporary empowerment

Several participants presented links between empowerment and drinking. Specifically, alcohol was used as a tool to mend powerlessness from past trauma (Doty-Sweetnam and Morrissette, 2018), increased self-esteem (Mackie, 2008), self-acceptance, and brought a sense of normality (Hood, 2003). Drinking allowed a sense of empowerment and ability to exercise their rights (Hood, 2003) and helped express and experience freely a sense of authentic 'self' that was silenced or hidden in non-drinking life (Boyd and Mackey, 2000). Heavy drinking, often perceived as a predominantly male activity, was often used as a marker of power and infused

women with a sense of empowerment and equality expressed by the ability to drink as much as men (Jacobs and Jacobs, 2014).

A participant in Boyd and Mackey (2000) describes the way by which alcohol assisted in gaining a temporary sense of power via the presentation of a competent and self-sufficient personality, one that could employ characteristics beyond the traditional female identity repertoire:

Because it [alcohol] defined.., it helped define who I was. You know I could be rough and tough, and I could stand with the best of them. And I could take care of myself. When inside I was really just a nothing, a nobody... And I see that pain behind a lot of peoples' eyes. That pain that says who am I? Will you please help me to find who I am? (pg.137)

Hood (2003), focusing on the notion of powerlessness, notes that social expectations and the desire to reclaim power and control in a societal structure that did not allow this was a primary motivation behind women's drinking. Alcohol, in this case, appeared to reduce perceived social constraints and offered a way, albeit temporary, to feel empowered and assertive:

When I was sober I didn't know what rights were. When I was drunk I have every right in the world and I would tell them non-stop. Drinking allowed me to stand up for myself. When I was drunk I had all the rights in the world. When I was sober I was garbage, I was refuse. (Bonnie cited in Hood, 2003 p.63)

Theme 3. Escalation of drinking and the dependent 'self'

While alcohol was initially used to alleviate discomfort via the facilitation of a substitute 'self' and reality as well as a temporary sense of empowerment, women identified a point whereby this

could not be sustained. Excessive drinking aiming to achieve the initial positive effects of empowerment and freedom created, instead, a cycle of shame and guilt, heightening preexisting emotional discomfort.

Alcohol at this stage was consumed compulsively; drinking was extended temporally to occupy the entire life scape (Mackie, 2008), lasting for days in a row and becoming a necessity in order to function (Paris and Bradley, 2001). Morning drinking to avoid withdrawal symptoms and devising ways to drink in secrecy (Lillie, 2002; Jacobs et al., 2012) were presented as part of the effort to recreate the initial positive effects and sustain the substitute, socially acceptable 'self.'. However, preserving a state of continuous intoxication became progressively unattainable and resulted in feelings of despair and hopelessness (Paris & Bradley, 2001; Lillie, 2002; Shinebourne and Smith, 2011).

"I was weak, I was stupid, I was bad.....I was a failure and a hypocrite, I presented a face to the world that wasn't me....eh...and I was very, very afraid. I lived almost continually in fear, that somebody would find out what I was really like." (Kathleen, as cited in Lillie, 2002, pg.102)

Excessive and continuous drinking led to the emergence of a new 'alcohol dependent self' who bore the shame and guilt from actions performed while drunk and could only be quietened via more drinking. The new 'alcohol dependent self' exacerbated the negative feelings that alcohol helped mask in the early stages (Mackie, 2008), and women were trapped in a cycle of drinking more to distance and disassociate from reality as things continued to escalate.

Stopping at this stage was not considered an option, and drinking continued on 'automatic pilot' (Mackie, 2008). Obsessive and continuous drinking became the norm while alcohol progressively overpowered every other aspect of women's lives (Mackie, 2008; Shinebourne &

Smith, 2009; Doty-Sweetnam and Morrissette, 2018). Participants reported feelings of being trapped, consumed alcohol compulsively, and despite the sense of unmanageability, they were unable to stop (Paris and Bradley, 2001; Lillie, 2002). Instead, alcohol consumption increased in an effort to achieve normality and function around people (Hood, 2003; Shinebourne and Smith, 2009; Nehlin, Fredrikson, and Oster, 2013). Carrying on the 'image' and positive qualities of the 'substitute self,' was nevertheless, short-lived as more alcohol was needed, escalating fast to drunkenness (Shinebourne & Smith, 2009) and unpredictability (Mackie, 2008). Blackouts, dissociation, and memory loss were described as the norm (Mackie, 2008; Pettinato, 2008) despite the realization that drinking could be fatal (Paris and Bradley, 2001).

Stigma and the cycle of shame

Women expressed both preexisting feelings of shame and guilt, which were, often, further exacerbated by the social stigma attached to being intoxicated. Participants reported encountering perceptions of promiscuity attached to drinking (Jacobs et al., 2012), a lack of acceptance from others, and their family's attempts to keep their drinking a secret (Jacobs et al., 2012; Jacobs and Jacobs, 2014). Social stigma was presented as leading to a sense of worthlessness and inferiority (Hanpatchaiyakul et al., 2017). Women who were raised in traditional families described expectations of 'being the good girl' (Jacobs et al., 2012), which led to the intensification of shame and prevented women from disclosing their addiction out of fear of facing disapproval or being punished (Brewer, 2006). A participant in Paris and Bradley (2001) reported that while her family was relatively accepting, their support was concentrated on advice to summon willpower as 'nice girls weren't alcoholic' (pg.653).

After extended periods of drinking or negative events during intoxication, participants described overwhelming shame, guilt, and self-hatred (Lillie, 2002). In a cycle of guilt and self-deprecation (Mackie, 2008), alcohol was used as a means to cover up the shame created by drinking (Mackie, 2008; Doty-Sweetnam and Morrissette, 2018), and participants would drink to avoid engaging with the humiliation caused by the 'alcohol dependent self' (Pettinato, 2008). The combination of shame and perceived social stigmatization, as well as the realization of the inability to stop drinking, led to additional feelings of being 'dirty' and 'tainted', leading to social withdrawal and isolation (Lillie, 2002).

Theme 4: The Recovering 'Self'

The recovery process was marked by the gradual transfer of power from external sources (other people, alcohol) to the 'self'. Expectations of external approval were reduced and gradually replaced by self-ownership, a sense of empowerment and agency manifesting in the ability to exercise choice, evaluate relationships, and regain control. Participation in recovery groups helped gradually move from concealing perceived problematic aspects of personality to increased self-expression, sense of belonging, and empowerment.

Turning points were different for every woman but were mainly guided by the belief that life with alcohol was no longer sustainable. The realization of being dependent on alcohol (Rowan and Butler, 2014) and acknowledging the harm caused to significant others, especially children (Prussing, 2007; Rowan and Butler, 2014), seemed to be motivating change in some cases. However, turning points appeared to consist of moments of despair (Prussing, 2007), hopelessness (Rowan and Butler, 2014), overwhelming pain which was no longer feasible to

numb (Mackie, 2008), and demoralizing lows' (Pettinato, 2008) that led to the realization that drinking could not continue (Paris and Bradley, 2001).

The preceding stage/theme consisted of the progressive escalation of drinking in an attempt to achieve an alternative 'self', opting out of reality or gaining strength and empowerment. The existence of a 'substitute self' is acknowledged in early recovery while women embarked on a process of identity transition. As alcohol temporally occupied the majority of women's life scape, some participants described feelings of loneliness, losing part of the 'self', not belonging, and attempting to determine their 'real self' (Mackie, 2008; Hood, 2003). As part of a discovery process, many women found that attending recovery meetings could provide a transitional safety net and a social network that could balance early sobriety's emptiness and loneliness (Hood, 2003). At the same time, women were coming to terms with the loss of alcohol's positive effects expressed through a notable ambivalence and nostalgia for the freedom alcohol could afford (Shinebourne and Smith, 2009).

Power and powerlessness

The concept of powerlessness was addressed in several articles focusing on AA and especially in the work of Bond and Csordas (2014). The first of twelve steps of AA (We admitted we were powerless over alcohol—that our lives had become unmanageable) and particularly the terms' powerlessness' and 'surrender' were part of most women's discourse. These terms played a significant role in the way recovery narratives were constructed and offered an explanation of their previous sense of despair and hopelessness experienced during what was described by some participants as 'rock bottom'.

Admitting powerlessness was presented as the first step towards ending the relationship with alcohol. Terminating the negotiations of control and power alcohol once had over their lives was perceived as a necessary precedent of agentic action. Alcohol was portrayed as a living entity with controlling and manipulative qualities and moderation as a futile attempt and illusion (Sanders, 2006). Declaring 'defeat', in this case, acted as a reversal of hopelessness while the knowledge that the fight between alcohol and the 'self' could cease was experienced as a source of empowerment (Bradley, 2011; Bond and Csordas, 2014).

Across the reviewed articles, women noted that engaging with the past and understanding previous behaviors was a crucial part of the process that led to recovery (Kornfield, 2014). Recovery itself was a learning experience that involved finding purpose in life (Hood, 2003) by examining past behaviors, revisiting and employing self-forgiveness for past actions, and attempting to discover and reinvent 'the self' on firmer foundations (Paris and Bradley, 2001).

Participants reported a realization that there was 'no sense of self' during active addiction, and a more solid feeling of 'me' was established in recovery (Bradley, 2011). Women in Hood (2003) discussed that their previous negative self-perception constituted a 'comfort zone' that was difficult to disengage from, whereas knowledge of 'the self' was experienced as a source of power and marked the difference between the drinking and recovering 'self' (Bond and Csordas, 2014). Sobriety was perceived as reclaiming power and control back from alcohol; winning over a powerful substance and surviving 'against all odds' was identified as a source of empowerment (Brewer, 2006; Bradley, 2011).

Empowerment

Several women identified a link between gender norms and restrictive societal expectations that required them to employ specific characteristics and behaviors. Roles such as those of wife, mother, daughter were often associated with traits such as being nurturing, prioritizing the needs of others, and having a non-agentic, secondary position. Noncompliance or unsuccessful fulfillment of these roles could lead to shame and guilt as well as self-harming behaviors, including alcohol use (Bond and Csordas, 2014).

Abby, an interviewee in Hood (2003), views that women are conditioned to be victims; however, this is not a role compatible with recovery:

...we are encouraged to stay the victim and to stay penniless. We're not encouraged to find our own power: I don't see how women can find love for themselves and their own recovery and healing without finding their own power and not being a victim anymore. I don't see how the two can they have to go hand in hand they have to you know. You can't stay a victim and be in recovery. But women have to be shown that, taught that. Because we are conditioned from the time we're born and put in our little pink frilly suits (Abby, cited in Hood, 2003, pg.64)

Several participants in Hood (2003) identified 'people-pleasing' and prioritizing the need of others as a prevalent and lifelong social expectation in the lives of women before recovery, extending to behaviors employed while attending AA:

You always have to, whenever the hand of AA reaches out, you have to be there, you know. Well, I'm sorry but women have been there for men their whole life and it's like, you know, for women sometimes recovery is NOT being there. It's learning not to help. (Bonnie as cited in Hood, 2003, pg.69)

Recovery involved the identification and alteration of lifelong patterns. Recognizing the impact of societal expectations and the weight of other people's views on their self-concept (Paris and Bradley, 2001), prioritizing their needs and taking responsibility for their lives rather than expect salvation through someone else (Paris and Bradley, 2001), self-acceptance instead of depending on the validation of others (Paris and Bradley, 2001; Hood, 2003; Kornfield, 2014), replacing judgement with self-compassion (Lillie, 2002; Kornfield, 2014) were reported as essential changes for women to progress in their recovery.

Recovery and the relational 'self'

Participants considered group participation as a form of protection from alcohol and essential in safeguarding their recovery, especially in the early days (Shinebourne and Smith, 2011). Women described their recovery communities as a surrogate family (Paris and Bradley, 2001; Brewer, 2006), in which they have been accepted with unconditional love (Bradley, 2011).

Going to meetings and having a sponsor created a sense of connectedness for many women (Bradley, 2011). Sharing without being judged, contrary to initial expectations, was described as freeing (Bradley, 2011; Kornfield, 2014), assisted in regulating negative emotions, and marked the initiation of self-acceptance (Bradley, 2011). On the other hand, listening helped identify with others, open up and get in touch with feelings and thoughts that had not been identified before (Rowan and Butler, 2014).

Building a sense of belonging was not a straightforward process as women were hesitant, felt not worthy of attending 12-step meetings (Prussing, 2007), or doubted the effectiveness of AA (Rowan and Butler, 2014). Regarding AA women-only meetings, participants described their past perception of other women as threatening (Sanders, 2010), competitive and untrustworthy

(Bradley, 2011) and initially doubted their relationship with their sponsors and other group members. These views were re-examined after participation and were associated with the relationship women had with themselves during addiction. A participant in the 'Circle of Women', a women's only group reported by Kornfield (2014), supported that addiction' pits women against one another' and recovery involves a 'self through others' relational re-evaluation and shift in relationships with men and women:

I found women to be petty, backbiting, envious. I took no delight in them whatsoever. So, most of the time I hung with the guys. I didn't want to hang with the girls because I probably didn't like myself. But I'm a woman. How can you not like women and you're a woman? (pg. 428)

After initial apprehension, participants reported finding the freedom to express themselves with issues that would not be feasible to discuss in mixed-gender meetings (Sanders, 2010), described as having the first honest relationships with women (Bradley, 2011) based on unconditional acceptance (Hood, 2003), which marked the process of learning to trust both the self and others (Sanders, 2010; Doty-Sweetnam and Morrissette, 2018). The majority of women expressed their apprehension in being open during mixed-gender meetings as matters related to relationships, health, sex work, or preexisting issues of sexualization by men could be misinterpreted as promiscuity (Kornfield, 2014). Similar apprehension and difficulties were mentioned in cases when past victimization, trauma, and sexual assault, often encountered in women's pathways, had to be disclosed (Sanders, 2010; Kornfield, 2014).

The next night I went to a women's AA meeting and discovered the reason for AA: Nearly every woman in that room had been raped, too. I felt scared, but I knew I could live through it, as they had." (cited in Sanders, 2010, pg. 28)

Although the difficulties encountered during participation in mixed meetings were significant, participants in Sanders (2010) and Hood (2003) expressed the view that both mixed as well as women-only meetings were essential in recovery as they offered a full range of views and assisted towards learning how to interact with both genders.

You know, every time things would be going well for me, I'd sabotage it somehow, and I've learned not to do that. It's a total learning urn experience for me-recovery. Ah, I learned that, the news that I had to love myself came as a great shock to me. Nobody had ever actually said that to me and yet my sisters and my brothers, they all knew it. I never knew it until somebody actually said to me because I was comfortable about feeling bad about myself (Cindy, as cited n Hood, 2003, pg. 68)

Consideration of findings across the reviewed articles revealed that feelings of ambivalence, initial apprehension, and reported difficulties relating to other individuals in meetings were part of a relational re-evaluation process. Covington and Surrey (1997) suggested that the relational element, inherent in the design of self-help groups, fosters relational growth. Through their participation in recovery groups, women were able to interact, establish boundaries, develop self-understanding, negotiate their role in groups, and discover and exercise agency by choosing the relational and physical spaces they occupied. Participants reported a more solid sense of the self (Bradley, 2011) that was no longer in flux (Shinebourne and Smith, 2011) as well as an ability to make conscious choices (Mackie, 2008), demonstrating a process from a non-agentic 'self' (pre-drinking/drinking) to gradual empowerment and development of agentic action.

Discussion and Implications

In this review, we synthesized the existing qualitative literature on women's trajectories from problematic drinking to recovery, intending to examine the mechanisms and processes involved in this process. The findings highlighted a complex trajectory involving profound identity transitions throughout the life course, influenced by the interplay of psychosocial factors intersecting with other forms of inequalities embedded in social structures. Although the role of trauma, victimization, and gender norms has been addressed previously in the literature examining the causal factors of heavy drinking and their implications for recovery, this paper has synthesized these elements to delineate the complex life long process leading to recovery. There are several observations to be drawn from the findings.

Firstly, we note the relational element located throughout women's life trajectories from childhood to initiation, escalation of drinking, and recovery. It has been previously supported that although recovery involves significant psychological changes, including an identity reconstruction (Biernacki, 1986; McIntosh and McKeganey, 2000), it can be better approached as a social rather than as a solely individualized pathway (Best et al., 2015). The accounts of women reviewed as part of this study revealed histories of adverse childhood experiences and a series of attempted connections and dis-connections from 'the self' and others, accompanied by 'survival' or emotional management strategies such as alcohol use. The role of agency is central in understanding the recovery pathways of women who drink. Women's accounts often appeared to be overpowered by structural and personal circumstances and, gradually, by alcohol, leading to diminished agency and transfer of control to external actors. Initiation of drinking could be seen as an act of identity restoration and rebalancing, agreeing with previous research (Killingsworth, 2006). Feminist literature has indeed positioned women's alcohol and drug use as an active agentic form of resistance and reclaiming of power (Anderson, 2008; Moloney et al., 2015), an

expression of spiritual and emotional needs (Ettore, 1992) as well as a gateway to sexual and spiritual freedom (Staddon, 2005). Dependence involved an increasing reliance on alcohol to achieve the initial feelings of empowerment, which gradually led to the exacerbation of preexisting distress and ascription of control to an external source. Recovery involved a 'self-through-others' re-evaluation, understanding and acceptance of 'the self' and a shift in re-defining powerlessness as the source of agentic action.

Women's accounts revealed their understanding of recovery groups as spaces of collective as well as individual empowerment. They reported a more solid sense of 'the self', negotiated their role, and exercised choice in the affective and physical spaces they occupied. Of considerable importance is the way in which women evaluated the therapeutic potential of each group and chose to participate in those that were conducive to their individual notion of recovery. Such groups offered opportunities for positive experiences of relatedness and trust and contrasted the previously occupied physical and affective spaces of vulnerability, victimization, and exclusion. It is important to note that the above was part of a gradual and lengthy process of growth that required revisiting and discussing traumatic events in spaces that were deemed safe.

Some of the findings should be interpreted alongside other literature in the area. Although some participants reported being empowered by their participation in AA groups, others revealed distress and negative reactions when disclosing their past in mixed-gender meetings, which, in turn, adversely affected their recovery. Lived experience accounts in the area argue that women's problems with alcohol are distinct from men's (Kirkpatrick, 1977), that the AA approach can be perceived as pathologizing (Staddon, 2005) primarily due to the emphasis on powerlessness and a life-long disease model (Kaskutas, 1994). Research studies identify several and diverse responses to group participation. For example, Neale (2018) suggests that women with complex

alcohol and other drug use do not necessarily wish to attend or find 'women-only' residential treatment beneficial, while earlier studies comparing self-help groups specifically created for women (Women for Sobriety) with AA groups, found that women could attend both groups for different reasons (Kaskutas, 1994). The findings of this article indicate that women in recovery are one heterogeneous group presenting a variety of common as well as different needs and personal histories. Participants in this review, for example, expressed concerns for both genders at the beginning of recovery, either in terms of trust (women-only groups) or in relation to disclosing sensitive issues in front of men. These concerns represented both the specific past experiences often shared by women as well as the relational difficulties that many encounter in early recovery. It is also necessary to highlight that recovery groups' practices that share common ideological foundations, such as AA, are not static and rigid, while local variations and varying responses to group dynamics can affect individual experiences (Kornfield, 2014). Although some women found mixed-gender meetings helpful, such an experience could be distressing, especially for women in early recovery and/or with trauma and abuse experiences. For example, previous research supports that male counselors are not appropriate to facilitate groups of female survivors from sexual victimization (Threadcraft & Wilcoxon, 1993), which is in agreement with the experiences of some participants in this review. Therefore, it is suggested that while treatment professionals evaluate clients' individual needs, a gender-responsive approach would require the recognition of histories of trauma, past experiences of treatment, as well as potential relational challenges that play a central role in women's addiction and recovery (Convington, 2002). It would also be useful for women with adverse experiences and those in early recovery to be informed both of the implications and potential benefits of participating in mixed-gender meetings.

Findings of this study indicate that feelings of shame precede alcohol use; women can experience chronic shame from an early age, which can be further exacerbated by the social stigma attached to drinking, reinforcing a destructive 'cycle of shame' which can be a significant barrier for recovery. Alcohol appeared to be used both as a way to manage core shame and shame that was reinforced by drinking itself. It has been established in previous literature that feelings of shame in women are associated with victimization, societal stigma, gender stereotypes, and experiences of addiction (Covington, 2008; Sanders, 2014; Kreis et al., 2016). DeYoung describes shame as: '*the experience of self-in-relation when 'in-relation' is ruptured and disconnected. A chronic sense of self in disconnection becomes a profound sense of isolation, which in turn leads to feelings of despair and unworthiness. (..) shame can be healed, therefore, if a person can be brought back into connection where empathy and emotional joining are possible'* (2015, pg.18). Similarly, Sawer et al. (2020) address the relational aspect of shame management in AA recovery groups and highlight the need for safe therapeutic environments that allow the creation of compassionate self-narratives. Shame is difficult to assess and can often be disguised or not identified in treatment, while brief interventions may create additional obstacles in addressing core issues and acknowledging shame. Moreover, it is likely that punitive approaches towards relapse or limiting group or treatment participation to specific criteria such as abstinence might intensify feelings of exclusion, isolation, and further shame. As feelings of shame have been linked to higher chances of relapse (Sanders, 2011), it is suggested that this is an area of importance for practice, and further studies are needed to understand the factors that facilitate shame management in recovery.

The accounts of participants in this review suggest that women can engage in heavy drinking as a way to correct preexisting feelings of powerlessness, escape structural constraints, and gain a

sense of empowerment and control. Previous research suggests that drinking in middle-aged women symbolized independence, facilitated a 'time-out' of domestic and parental responsibilities, and allowed them to assert their identity beyond the roles associated with this age group (Emslie et al., 2015). The practice employed by the alcohol industry often draws on postfeminist representations and discourses that link drinking to independence, empowerment, assertiveness, and ‘bold’ feminity (Bailey et al., 2015). Participants in the reviewed studies sought temporary empowerment and independence in the initial stages of drinking and attempted to recreate these positive feelings even when drinking became problematic; these idealized emotional states created ambivalence in early recovery. Recent research demonstrates that young people and those with a history of alcohol dependence can be especially susceptible to alcohol marketing (Babor et al., 2017). Therefore, it is suggested that greater public health benefits may be achieved by stricter regulations and protective measures that limit marketing strategies that align alcohol with female empowerment and promote content that draws on idealized effects of drinking and normalize alcohol as a response to life stressors.

Limitations

The above findings should be considered within the study's limitations, most of which are representative of the broader limitations in the existing literature. Firstly, due to the methodological search criteria, the reviewed articles were limited to English-language and those focusing only on alcohol. Secondly, the outcomes of the search suggest a significant issue in 'gender-blind' reporting, in agreement with previous related research (Fitzgerald et al., 2016; Page, 2019), a geographical disparity with the majority of studies conducted in the US as well as a limited amount of research in settings other than AA. Moreover, the majority of studies

followed a 'substance-blind' approach, limiting the amount of reviewed literature considerably and contributing to the gap in knowledge, especially when considered alongside the 'gender-blind' manner of reporting. Inconsistencies were also encountered in the reporting, or lack thereof, of participants' stage of recovery and approach (abstinence or reduction in drinking). It also needs to be noted that there was an absence of research looking into women's alcohol recovery in secure settings within the chronological and other criteria set for this study.

The majority of the reviewed research involved women who had received support from AA and, as a result, their accounts were constructed around the discourse, and 'narrative template' often shared in 12-step groups (O'Reilly, 1997). Therefore, accounts of recovery were situated within the systems in which they have been created, and relevant concepts (for example, powerlessness, surrender) used in this review reflect the participants' discourse. Consequently, narratives from those attending groups with different ideologies and various cultural backgrounds would have offered a more diverse and richer dataset.

The reviewed studies' participants have been predominantly alcohol-dependent and heavy drinkers, and therefore not all drinking, and recovery experiences are represented. Moreover, the process described in this article is an indicative one and should be approached as a series of realities based on participants' accounts embedded in the social systems they occupy rather than an attempt to establish causal links and present one unique trajectory.

Conclusion

Existing research suggests that gender factors are present in addiction and recovery journeys. This study employed a holistic approach to synthesize the social and structural contexts of women's lives, the psychological factors that precede addiction trajectories, and how these affect the transition and maintenance of recovery. Although there might be commonalities between men's and women's addiction trajectories generally, women present with different profiles that require individually tailored approaches. Women's accounts indicate a complex interplay of adverse life histories that have been shaped and significantly affected by internalized public perceptions and social inequalities. These factors defined the reasons for the initiation of drinking, obstructed attempts to seek help, and created additional hurdles when participating in recovery groups and services that were not designed to be gender-specific. It is of significant importance that women's complex trajectories and the lived structural disadvantages these have been defined by are accounted for in both policy and treatment. The reviewed literature's limitations present an additional need for more research into the mechanisms and processes of recovery, especially in under-researched populations, settings, and recovery approaches. Knowledge in the area will also benefit greatly by encouraging authors to differentiate and report findings by gender as well as by substance.

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The authors report no conflicts of interest.

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* denotes the papers/studies were included in the meta-synthesis (see table 1)

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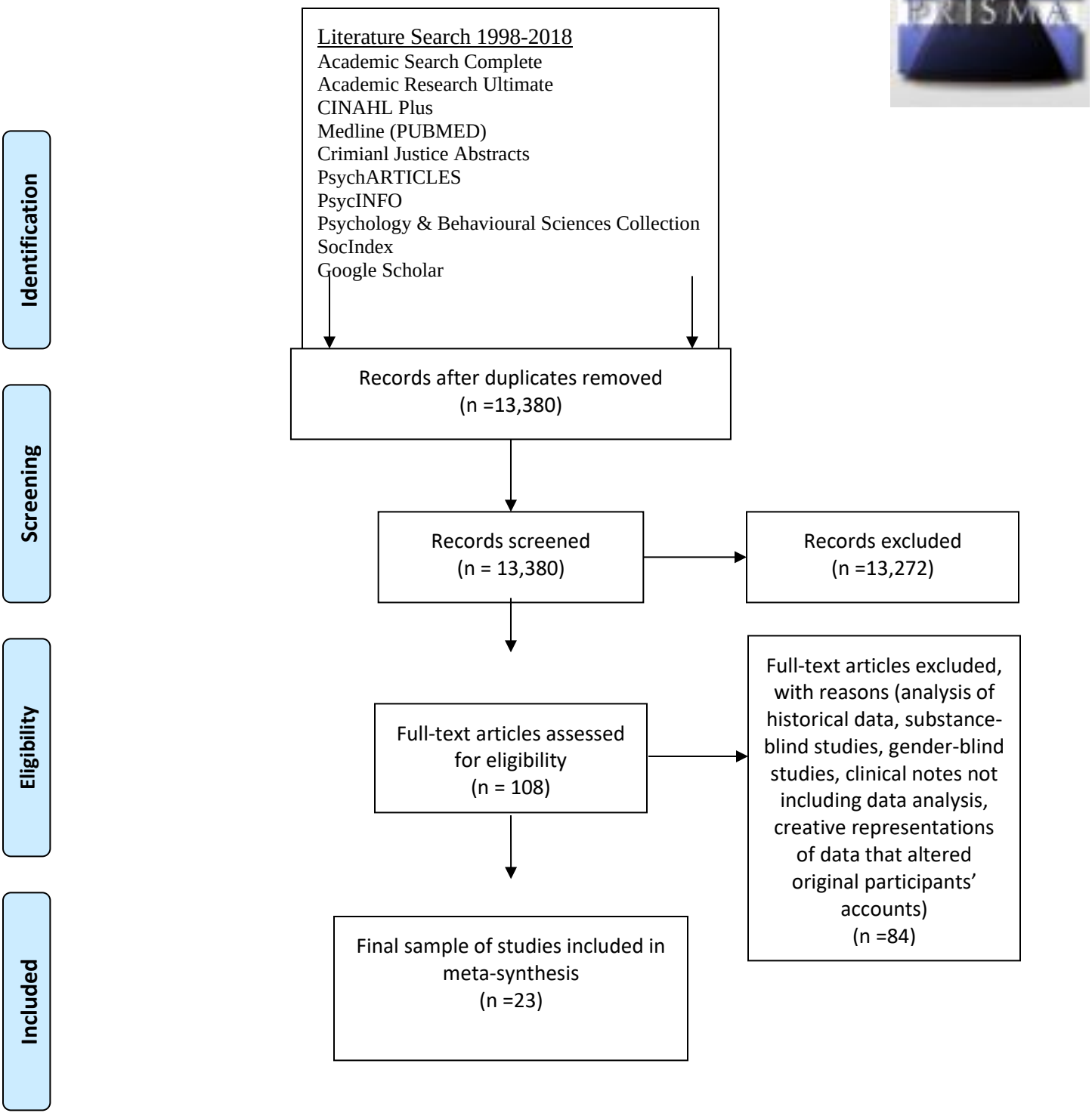

Figure 1

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Table 1: Studies included in the review

Authors	Aims	Country	Sample	Recruitment	Methods	Type of programme attending/attended
Boyd and Mackey (2000)	To describe women's perspectives in becoming alcohol dependent.	USA/not clearly stated	14 women, Black & White, (aged 26-53).	Purposive sampling from women's groups at Substance abuse treatment centres in rural counties	Interviews	Substance abuse treatment centres
Paris and Bradley (2001)	To present psychosocial development of women involved in Mills Longitudinal Study.	USA	3 women (early 60s) who had achieved abstinence	Participants from the Mills Longitudinal Study based on a representative sample of the senior classes at Mills College in 1958 and 1960.	Narrative Interviews	AA and support groups
Lillie (2002)	To explore the self-concept and self-esteem of women with alcohol problems.	Scotland	8 women (aged 38-63), all had person-centred counselling, 4 currently abstinent	Recruited from Edinburgh alcohol service on basis of self-defining as having serious alcohol problems	Open-ended interviews	A range of 'treatments' inc. counselling, group therapy, AA, aversion therapy, drug treatment and in-patient detoxification and RP
Hood (2003)	To investigate the role of leisure in the recovery process of women.	USA	3 women in recovery between 4-10 years,	Via personal acquaintance allowing access to the group and women's willingness to participate.	Semi-structured in-depth interviews, three focus groups, and meeting observations (non-AA)	Own-formed support group/recovery network outside AA
Brewer (2006)	To identify the contextual factors that fostered or hindered the process of recovery.	USA	11 women (aged 32-76), in recovery 2-37 years	Networking and snowball sampling	Interviews	AA, SOS, Rational Recovery
Sanders (2006)	To provide insight into how women in AA approach, interpret, and utilize the Twelve Steps in recovery.	USA	167 women, predominantly white from 26 different meetings	AA women-only meetings listed in the AA directory	Survey answers and personal narratives provided	AA

Prussing (2007)	Describes how addiction/recovery discourse has been selectively engaged by the younger generation.	USA	35 North Cheyenne women (aged 18-84)	Recruited from Recovery Centre in the Northern Cheyenne Reservation	Open-ended interviews	12 step programmes
Pettinato (2008)	To develop a substantive theory regarding the life experience of the alcohol among lesbians.	USA	13 lesbian women (although one identified as bisexual) (aged 43-62), 4-26 years in recovery (apart from one who was still drinking), mostly Caucasian	Invitational flyers, advertisements inviting voluntary participation in newspapers, and word of mouth.	Interviews	Not specified
Mackie (2008)	To examine the author's years of drinking and her "journey towards sobriety".	USA	1 woman	N/A	Autoethnographic essay	AA implied but not confirmed
Sobczak (2009)	Explores the experiences of women who were dependent on and the relation between alcohol abuse and sexual function.	USA	13 women (aged 25-45), abstinence 14 days-13 years	Purposive and network sampling, through advertisements in local newspapers, also word of mouth	Interviews and observations	12-step
Shinebourne and Smith (2009)	How experiences of addiction and accompanying feelings, thoughts and expressions appear to the participant in the context of her life.	UK	1 woman (aged 31)	One of four women who agreed to be interviewed for a larger study of women's experiences of addiction and recovery from a Women's Day Centre	Semi-structured interviews	Women's day centre
Sanders (2010)	Examines, from a feminist perspective, the participation of women in the gendered space of women-only AA meetings.	USA	167 women	Non-probability sample of woman who attended women-only AA meetings on the AA directory in that area (from 26 meetings)	Survey with structured and open-ended questions	Women-only AA meetings
Bradley (2011)	To examine how specific practices within AA assist women to develop an understanding of spirituality that promotes and sustains sobriety.	USA	29 women (aged 40-75) predominantly white, abstinence ranged from 2 days-25 years	Recruited from AA women's discussion meetings	Five face-to-face non-directive structured focus groups	AA

Shinebourne and Smith (2011)	To explore experiences and understandings of those who have engaged with the process of recovery.	UK	3 women, (aged 30s-50s), min. 15 years abstinent	Snowballing sampling	Semi-structured interviews and participants' drawings	AA
Nehlin, Fredriksson and Oster (2013)	Explores high risk-drinking young female psychiatric patients' view of the role of alcohol in their lives.	Sweden	9 women (mean age 22.2 years)	Women who were previously enrolled in a Brief alcohol intervention	Semi-structured open-ended interviews	Psychiatric outpatient setting
Bond and Csordas (2014)	To question how women in AA navigate and negotiate the contradictions found within a male-dominated and centred program.	USA	10 women (aged 26-54), abstinence min. 3 years	Recruited from AA	In-depth interviews	AA attending women's only and home meetings
Rowan and Butler (2014)	Examines the lived experiences of older lesbians with alcoholism and their journey to and maintenance of sobriety.	USA	20 lesbian women, (aged 50-70), min. 1-year continuous abstinence	Purposive and snowball sampling via recovery and treatment centres, Web sites, coffee shops	3 in-depth interviews per participant	Not specified? N/A
Kornfield (2014)	Explores how women portray the role of individual and social forces in their addictions.	USA	10 Black women	Recruited in person from Circle of Women	Participant-observations at mixed-sex AA meetings at "Mount Zion Hospital" and at Circle of Women (a monthly women-only group) and interviews	AA, Circle of Women (not AA related) women only

Jacobs and Jacobs (2014)	Life stories about South African mothers' who had a heavy drinking problem and their barriers to accessing treatment.	South Africa	10 women (aged 30-65), 70% white.	Purposive & snowballing sampling, via collaboration with Western Cape AA office records.	Narrative interviews	AA
Jacobs, Naidoo and Reddy (2014)	To (a) explore women's alcohol dependence history and treatment history (b) identify barriers and nature of barriers that limit women's access to alcohol dependence treatment and (c) identify the reasons for women not accessing treatment..	South Africa	As above	As above	Life story (narrative) interviews	AA
Doty-Sweetnam and Morrissette (2016)	To share individuals' journey and experience of those in recovery and provide information on recovery strategies utilized.	Canada	7 Mannitoban First Nations and Aboriginal women (aged 32-68 years)	Recruited from First Nations and Aboriginal Friendship Centre's throughout the Province of Manitoba	Individual interviews	Mainstream treatment approaches (e.g. AA, family support programs), traditional healing practices, or a combination
Gee et al. (2017)	To present one person's voice of her journey from addiction to recovery.	USA	1 woman (aged 59)	Recruited from a larger study examining life patterns of 9 people in recovery	Life story narrative of an individual from a larger study	12-step group
Hanpatchaiyakul, et al. (2017)	To explore the lived experiences of women in relation to alcohol addiction in treatment.	Thailand	12 women (aged 20-65) who had experienced alcohol addiction for at least 3 years	Purposive snowball sampling from two special hospitals, one outpatient clinic in a general hospital	Interviews	Some attended AA

UK = United Kingdom; USA = United States of America; AA = Alcoholics Anonymous; SOS = Seculars for Sobriety; RP = relapse prevention