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RESEARCH ARTICLE

Impact of the COVID-19 pandemic on students with relatives with addiction problems: A longitudinal qualitative study

Dorine M. van Namen[1,2] | Sander R. Hilberink[1] | Hein de Vries[2] | Gera E. Nagelhout[2,3] | AnneLoes van Staa[1]

[1]Research Center Innovations in Care, Rotterdam University of Applied Sciences, Rotterdam, The Netherlands

[2]Department of Health Promotion, CAPHRI Care and Public Health Research Institute, Maastricht University, Maastricht, The Netherlands

[3]IVO Research Institute, The Hague, The Netherlands

Correspondence
Dorine M. van Namen, Department of Health Promotion, CAPHRI Care and Public Health Research Institute, Maastricht University, POB 616 6200 MD, Universiteitssingel 40, 6229 ER Maastricht, Maastricht, The Netherlands.
Email: d.vannamen@maastrichtuniversity.nl

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Rotterdam University of Applied Sciences

Abstract

Addiction problems impact not only the persons with these problems but also family members. This study aims to examine the impact of the COVID-19 pandemic on stress, strain on health, study experiences, coping strategies, and access to support of students with relatives with addiction problems. Thirty students, aged 18–30 years, from a University of Applied Sciences in the Netherlands participated in a three-year qualitative longitudinal interview study. One round of individual semi-structured interviews was conducted before the COVID-19 pandemic, and three during the COVID-19 pandemic. Directed Content Analysis was applied, using the Stress-Strain-Information-Coping-Support-model. Four major themes were identified: (1) Increase in stress and strain; (2) Decrease in stress and strain; (3) Coping strategies, and (4) Access to social, professional, and educational support. Before the pandemic, most participants had health problems, especially mental health problems, including problems with their own substance use. Some had study delay. Analysis revealed that during the pandemic, most participants experienced an increase in these problems. This appeared to be related to their living situation: An increase in violence and relapse of relatives increased stress, especially for those living with their relatives. The coping strategies 'standing up' or 'putting up', and a decrease in support—social, professional, and educational—also contributed to stress. A few participants experienced less health problems and study problems. This was related to diminishing addiction problems of relatives, less social pressure, available help, and the coping strategy 'withdrawing'. Withdrawing was much easier for participants who did not live with their relatives with addiction problems. It is recommended to keep schools and universities open during pandemics, offering a safe haven for students at risk in the home situation.

KEYWORDS
addiction, affected family members, COVID-19, mental health, qualitative research, students, study success, young adults

1 | INTRODUCTION

Addiction is a major societal problem that impacts not only the person itself, but also family members such as (adult) children, siblings, and partners (referred to collectively as Affected Family Members [AFMs]). To describe and explain the experiences of AFMs, Orford and colleagues designed the Stress-Strain-Information-Coping-Support-model (SSICS) (Figure 1) (Orford et al., 2013). This model assumes that having a relative with addiction problems[1] is highly stressful for AFMs. In families with such addiction problems experiencing or witnessing physical, emotional, and/or sexual violence is common (Choenni et al., 2017; Orford et al., 2013; Velleman & Orford, 1999) and often traumatic (Van der Kolk, 2022). AFMs may also have their properties damaged, get into financial problems, have to leave home or take care of the household or younger siblings (Kelley et al., 2007; Laslett et al., 2019).

The consequent strain may affect AFMs' mental and physical health. AFMs generally experience poor health, often related to chronic stress, depression and anxiety, concentration problems, and sleeping and eating problems (Orford et al., 2013; Velleman & Templeton, 2007, 2016). AFMs also use more addictive substances than people who do not have relatives with addiction problems (Orford et al., 2013; Rossow et al., 2016; Van Namen et al., 2022). Having a relative with addiction problems is bound to put AFMs' health at risk (Orford et al., 2010) and may also affect study performance, although research on educational outcomes is limited (Kuppens et al., 2020; Lowthian, 2022).

The SSICS-model posits that AFMs' stress and strain are mediated by the positive or negative influence of the coping strategies they use and the extent and quality of the social and/or professional support they receive (Toner & Velleman, 2014). The model identifies three coping mechanisms: to put up with it (to accept things as they are or even accommodate the relative's substance use), to stand up (getting aggressive or trying to control their relatives' drinking or drug taking, trying to minimise harm for other family members, supporting the relative to seek treatment) or

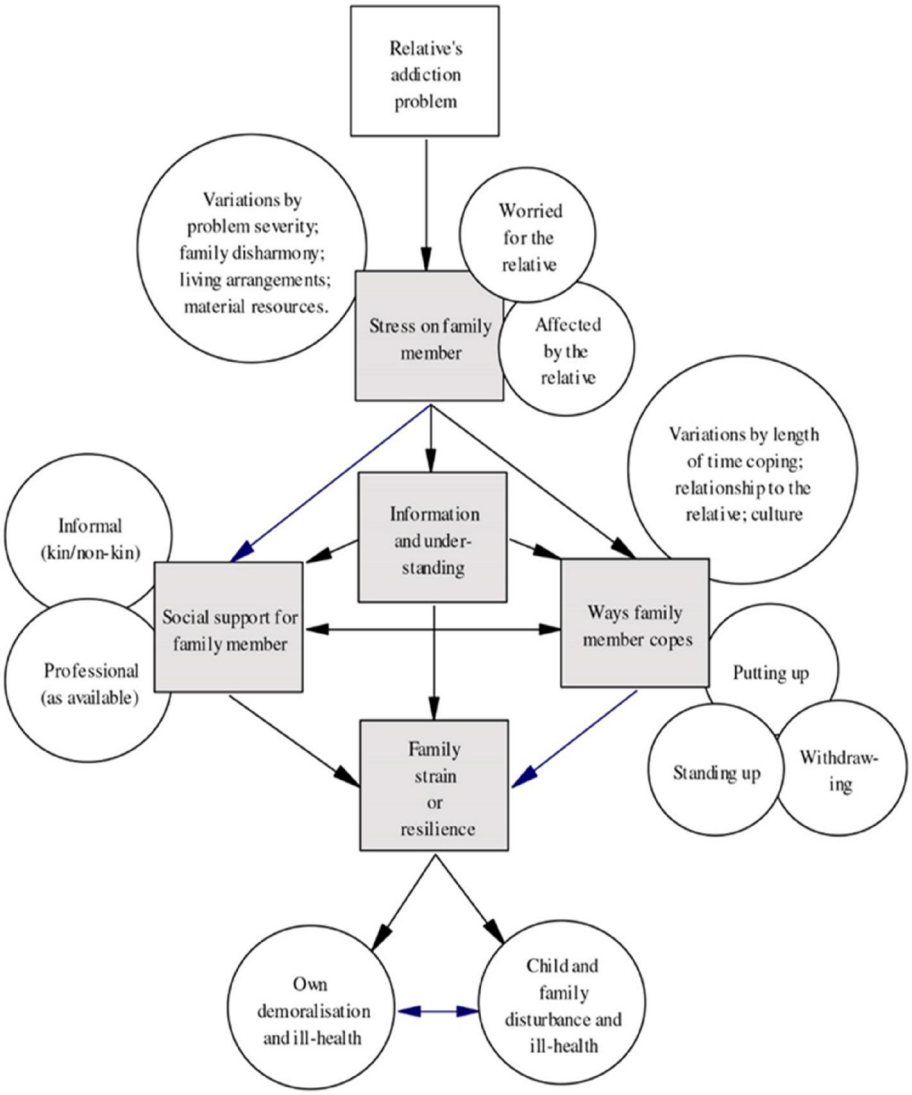

FIGURE 1 Stress-strain-coping-support model.

to withdraw and try to maintain independence (to take what is happening less personally, getting involved in other activities, escaping or getting away and getting a new and better life for oneself) (Orford et al., 2013). A basic assumption of the SSICS-model is that AFMs are not powerless, but can improve their life circumstances and health (Orford et al., 2010).

How the Coronavirus Disease 2019 (COVID-19) affected AFMs, has hardly been studied. In several countries, family violence increased during the COVID-19 pandemic (Boserup et al., 2020; Usher et al., 2020; Zhang, 2020). Mental health problems of adolescents and young adults worsened because of social distancing recommendations (Bosmans et al., 2022; Bu et al., 2020; Gobbi et al., 2020; Hao et al., 2020). Consumption of alcohol and cannabis increased during the pandemic (Ahmed et al., 2020; Berndt et al., 2017; Firkey et al., 2020; Gritsenko et al., 2021; Papp & Kouros, 2021), as did overdosing counted by visits to emergency departments in the US (Holland et al., 2021). The pandemic also worsened existing learning gaps: those from disadvantaged backgrounds faced greater challenges adapting to school closures and online education (OECD, 2021). A systematic review found that female gender, younger age group (≤40 years), presence of chronic/psychiatric illnesses, unemployment, student status, and frequent exposure to social media/news concerning COVID-19 were risk factors for stress and distress during the pandemic (Xiong et al., 2020). Students with relatives with addiction problems tick most of these boxes and could well be another disadvantaged group.

Therefore, this study aims to examine the impact of the COVID-19 pandemic on stress, strain on health, study experiences, coping strategies, and access to support for students with relatives with addiction problems.

2 | METHOD

2.1 | Design

This study is part of a 3-year longitudinal qualitative interpretive study consisting of in-depth, individual semi-structured interviews with students in higher education in the Netherlands who have relatives with addiction problems. Interviews were conducted once before the COVID-19 pandemic and three times during the COVID-19 pandemic. The frequency of contact was planned (once per year), except for an additional interview round when COVID-19 just broke out. For a timeline of the events and decisions surrounding COVID-19 in the Netherlands and the months the interviews were conducted, see Figure 2.

Longitudinal Qualitative Research (LQR) is suitable when researching transitions in life course issues, transitions to adulthood,

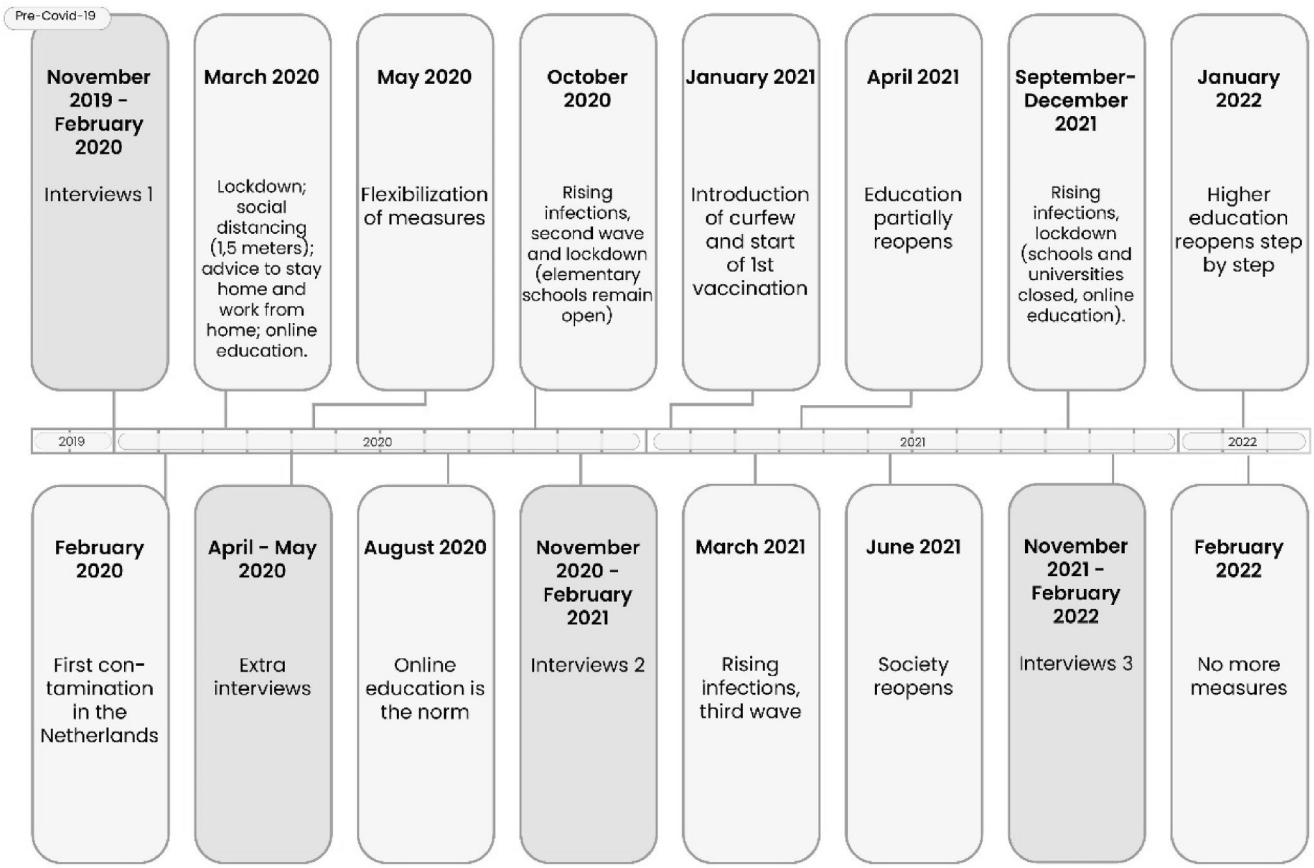

FIGURE 2 Timeline Covid-19 pandemic in the Netherlands (Central Government, 2022).

identity construction (the way individual biographies evolve), resilience (the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioural flexibility and adjustment to external and internal demands [APA, 2023b]), and family lives (the intersection between personal and family lives and social structures; the impact of key life events) (Crivello, 2017). Therefore, the decision was taken to use LQR to study the impact of COVID-19 on the lives of students with relatives with addiction problems. The consolidated criteria for reporting qualitative research (COREQ guidelines) were followed (Tong et al., 2007).

2.2 | Participants, recruitment, and sampling

2.2.1 | Recruitment of participants

Students at Rotterdam University of Applied Sciences (RUAS) in the Netherlands who had participated in an online survey sent in December 2018 (with reminders sent in December 2018 and January 2019) on their own substance use were invited for the present study. The survey also included questions about the substance use of their relatives and was used as a screener. Eligible students were those who (1) responded positively to the question 'Is there anyone in your family with behavioural and/or health problems caused by alcohol/drugs/medication, such as painkillers, sleeping medications, or tranquilizers?' (n = 881), and (2) provided contact details (n = 105 of 881). A message about the above-mentioned study was posted on the intranet of The Hague University of Applied Sciences (HUAS), including the first author's contact information. Four HUAS students subsequently sent a message to the first author, two of whom eventually did not want to participate. Initially, only a few men wanted to participate. To recruit more men, we invited the men an extra time. This resulted in an additional five male participants. To include more participants from diverse cultural and ethnic backgrounds we used social media and tried to get in touch with these groups through colleagues from different ethnic backgrounds and culturally diverse student organisations. These attempts provided no extra participants. Students older than 30 years were excluded. The eligibility of all participants was confirmed by the first author before the first interview.

We then applied purposive sampling (Etikan, 2016), aiming for an equal distribution of genders, and to compose a diverse group based on the study programme, study year, religion, type of substance use of the relative, and relationship to relatives. Based on this sampling method, 30 students were included for interviews in the first year (2019–2020): 28 from RUAS and 2 from HUAS. Twenty-six of them participated in the second year (2020–2021), and 24 in the third year (2021–2022). To examine the impact of the COVID-19 outbreak in 2020, 14 participants were interviewed in the first months of the outbreak (Figure 2). These interviews were not preplanned. Students could participate if they had time and wanted to be interviewed an extra time, but they were not repeatedly asked to participate in this extra round.

In total, 28 students (93%) participated in at least two interviews, and 24 students (80%) participated in three or four interviews. Two students participated only once, in the first interview round. Reasons given for withdrawing from the study were: being too busy after graduation, not wanting to stir up difficult family relationships anymore, having serious mental health problems, or the death of the relative with addiction problems. During the interviews not only was problematic substance use addressed but also gambling and sex addiction. Therefore, we use the term addiction problems to refer to all of these problems.

2.3 | Development of qualitative interview

The interview topic list (Appendix) was derived from the SSICS-model and contained open-ended questions based on the main categories of the SSICS-model (Stress, Strain on participants' health, social life, and study experiences, Information, Coping, and Support). In the second and third years, the same topics helped to detect change at the individual and group levels, while the added questions addressed the impact of the COVID-19 pandemic. All interviews were conducted by the same researcher (DvN).

The first-year interviews were conducted in person and lasted on average 78 min (range 53–116 min). The interviews were conducted at the university premises or in a public location, according to the preference of the interviewee. The interviews in the additional interview round were conducted online and lasted on average 23 min (range 15–33 min). For online interviews, the communication platform Microsoft Teams was used. The interviews in the second and third years were conducted either online or live, and lasted on average 78 min (range 38–133 min). Face-to-face interviews were conducted at interviewees' homes, at the university premises, or in a public location. The choice depended on the interviewee's preference and also on the opening of buildings and public spaces during lockdowns. The online interviews went relatively smoothly since a relationship between the respondent and the interviewer had already been established during the first, face-to-face interview. At the end of each interview and the beginning of follow-up interviews, the participant received a verbal summary of the key findings from the previous interview for member checking.

In between interviews, the interviewer maintained, on average twice a year, personal contact with the participants through email and text/voice messaging app WhatsApp, for example, about the progress of the study, the student's study progress, or graduation. Interviews were recorded digitally, transcribed verbatim, and anonymised for analysis. Transcriptions were made by a student not affiliated with the universities involved, to prevent recognition of a fellow student. This student signed a declaration of confidentiality. Participants were informed (verbally and in writing) about the aim of the research and the procedures (voluntary participation, anonymity),

including the fact that they could end their cooperation at any time. Participants were not compensated. Participants could ask questions or raise concerns before data collection. All participants had signed an informed consent statement.

2.4 | Data analysis

Data were analysed with the Directed Content Analysis procedure. Directed Content Analysis is used for qualitative analysis to validate, refine and/or extend a theory (i.e., SSCIS-model) in a new context (Assarroudi et al., 2018; Hsieh & Shannon, 2005). Seven steps were followed (Assarroudi et al., 2018). (1) Two researchers got immersed in the data. (2) Before coding, a formative matrix of the main categories (Stress-Strain-Information-Coping-Support) and related subcategories (for example Stress: aggression; mortal danger; behaviour relative) was deductively derived from the existing theory and previous research. (3) The main categories were defined and supplemented by examples. (4) Anchor samples for each main category were added. (5) The first-round interviews were then coded by two researchers independently (DvN and a research assistant). They read and reviewed the transcripts several times, discussed the coding, the categorisation matrix, and any disagreements until agreement was reached. (6) New codes, retrieved inductively from the data, were added (for example, Stress: substance use relative [increase, relapse, overdose]; death relative; illness relative). (7) Codes were organised in an iterative process using summary tables. The analysis outcomes were discussed by the entire research team, after which some refinements and additions were made. This led to a final codebook with 58 codes. Subsequent follow-up interviews were coded by the first author using the code book of the first round, which then was supplemented with codes about COVID-19 and the longitudinal character of Stress and Strain. The final codebook comprised 62 codes. The analysis and coding processes of all follow-up interviews were critically reviewed by a second researcher (AvS) and followed by a discussion to resolve disagreements. These analysis outcomes were also discussed by the entire research team, after which some refinements and additions were made. In the analytic phase, we combined synchronic and diachronic analyses and both retrospection (participants' recollections of the past) and prospection (participants tracked in real-time, recording change in successive rounds). The first step was a cross-sectional (synchronic) analysis of the latest round of data, followed by a longitudinal (diachronic) analysis. Data analysis was performed using Atlas.ti® 22.

2.5 | Research team and reflexivity

The female interviewer (MSc) (DvN), 57 years old at the start of the interview series, is an experienced journalist and qualitative researcher at RUAS. She had relatives with addiction problems. Her personal experiences were an important motive for doing the research. To earn trust, she told the participants that she had experience on the subject, but did not elaborate on her experiences. Participants valued this information and told the researcher it made them feel less ashamed and made it easier to talk about their experiences. Although the first interview was the first time participants and interviewer met (after communicating through phone or e-mail), a relationship between the interviewer and participants developed, because of the intimacy of what was discussed and the long-term nature of the study. The second coder (research assistant VK) had no experience with addiction in her family. The research group as a whole consisted of a mix of people with and without experiential expertise on addiction in the family.

3 | RESULTS

3.1 | Participants

Nineteen of the 30 participants (mean age 22.9, SD 2.7) were women, and 11 were men. Participants had a total of 107 relatives with addiction problems (mean 3.6, SD 2.0) in their extended families, of whom 58 were in their nuclear families; three had one relative with addiction problems. Alcohol use by relatives was most common, often in combination with drugs or painkillers, sometimes also in combination with gambling or sex addiction (Table 1).

Four major themes with subthemes were identified: (1) Increase in stress and strain (subthemes: Living situation; Pre-existing health problems; Substance use of participants; Studying from home); (2) Decrease in stress and strain (subthemes: Diminishing addiction problems of relatives and less social pressure; Studying from home); (3) Coping strategies and (4) Access to social, professional, and educational support.

3.2 | Increase in stress and strain

3.2.1 | Living situation

Participants living with relatives with addiction problems during the pandemic—albeit a minority of the study population—reported an increase in stress. These relatives normally benefit from the structure of their lives as these participants explained. Yet, addiction problems worsened during COVID-19 when, for example, relatives had to work from home or became jobless. As a result, violence committed by some relatives with addiction problems towards participants got worse.

> Especially when I had to stay at home, the bomb burst. It was a war zone here. There was no escape. It was a disaster for me to be at home. He [partner] kicked the

TABLE 1 Characteristics of participants.

	Baseline N = 30
Age in years	
17–20	4
21–24	20
≥25	6
Mean (SD)	22.9 (2.7)
Study programme	
Economics	5
Social studies	7
Health care	5
Art	2
Media and ict	5
Teacher training	3
Engineering	3
Study delay (yes)	11
Lives in same house as relative with addiction (yes)	9
Relative died due to drinking and/or drugs	3
Number of relative(s) with addiction in nuclear family	
1 relative	10
2 relatives	14
3 relatives	4
4 relatives	2
Number of relative(s) with addiction in extended family	
1 relative	8
2 relatives	5
3 relatives	3
4 relatives	3
≥ 5 relatives	2
Total number of relatives with addiction in family	
1 relative	3
2 relatives	11
3 relatives	2
4 relatives	4
≥ 5 relatives	10
Relationship with relative with addiction in nuclear family[a]	
Father	14
Mother	13
Stepmother	1
Stepfather	6
(Step)siblings	12
(Ex-)partner	5
Type of relative's addiction in nuclear family	
Alcohol only	11
Drugs only	1
Poly use (combinations of alcohol, drugs, gambling, sex and/or tranquilizers)	18
Ethnic background	
Dutch	26
From Suriname and Netherlands Antilles	2
From another Western country	2

[a]Participants can have more than one relative with addiction.

> shit out of everything and smashed the furniture to pieces. He just flew into a rage.
>
> (P6, 2nd interview, woman, 25yo)

Others locked themselves up in their rooms until their relatives *'were comatose'*, a situation these participants described as claustrophobic. Some relatives relapsed after a period of abstinence, which increased stress on family members.

> That drug use of my brother is a big thing for me, even without COVID, but it got worse now because he relapsed and we were in lockdown. I could not escape from it. My stress got much worse.
>
> (P25, 2nd interview, man, 22yo)

One participant described that her relative started to use a different type of alcohol during COVID-19.

> It got worse during the pandemic. She had less and less time [to drink] because my stepfather was at home. So then all of a sudden she started using fifty percent vodka. So it all happened much faster and it was much more intense. And that lying and cheating got more and more intense too.
>
> (P30, 3rd interview, woman, 23yo)

Stress increased when negative life events took place, such as the break-up of a romantic relationship. The latter triggered strong feelings of rejection, resulting, as participants stated, from life with relatives with addiction problems. These feelings could even be triggered by strangers on the street:

> That one and a half meters [distancing] I find annoying, especially when people look at me angrily. Then I think they are angry with me or dislike me, even if I don't know them.
>
> (P19, 2nd interview, woman, 28yo)

3.2.2 | Pre-existing health problems

For most participants who had mental health problems before the pandemic (the majority of the total sample), their problems increased during the pandemic, especially at the beginning. Relatively more women than men reported an increase in mental health problems.

> For me, it's very hard to be alone, I am always looking for other people. I feel lonely and isolated. And that gives me extra anxiety and stress.
>
> (P13, 2nd interview, woman, 24yo)

For some participants, problems surfaced during the pandemic.

> The way I see it now is that throwing myself into a routine, planning everything, made me feel like my core was healing. But when COVID-19 threw me out of that routine, then that whole house of cards collapsed, and I found out that my core did not heal at all.
>
> (P9, 3rd interview, man, 26yo)

Participants whose relatives had died as a result of addiction problems also experienced more mental health problems. At baseline three participants had lost a relative as a result of addiction problems. In the last round of interviews, this figure had risen to five.

> My grandfather died during the second wave. Everything from my mother and my mother's death came back rock-hard. That is when the panic attacks also came back, especially in public transportation. I couldn't get on a train or bus anymore. I do think that had to do with my mother's death.
>
> (P10, 4th interview, woman, 26 yo)

An increase in mental health problems was not related to the type of relationship with the relative.

3.2.3 | Substance use of participants

Participants who called themselves addiction-prone before the pandemic reported more problems with substance use or gaming during the pandemic. Spending a lot of time at home without having obligations and structure made it harder for them to control their substance use or gaming behaviour.

> Alcohol dragged me through COVID-19. After work, we'd have a nice glass of wine and we continued to drink the whole evening; basically, we did that every day. That habit is difficult to break.
>
> (P11, 2nd interview, woman, 25yo)

A few felt thrown back into a lifestyle of gaming, staying indoors, and only having social contact online.

> Before COVID-19 I had left that lifestyle behind me. Now I almost feel forced to pick up my old life again.
>
> (P17, 3rd interview, man, 33yo)

For most participants, the increase in their own substance use happened at the beginning of the pandemic. Over time their substance use fluctuated or even returned to pre-pandemic levels.

3.2.4 | Studying from home

The majority of the participants experienced problems with concentration, discipline, motivation, and procrastination, having problems finding or keeping an internship, and concerns about the value of their educational degree. Participants who lived with their relatives had more practical problems with studying at home while the university was closed.

> My room is too small for a desk. The only good place to study is the living room. But a lot is happening there and more noise. Otherwise, I have to lie on my bed to study, and, well, that's not an active study position.
>
> (P28, 2nd interview, man, 21 yo)

Other participants related their pre-existing mental health symptoms to keep them from actively contacting teachers or fellow students. A few participants said there was no one to encourage them and that some teachers had no idea what might be going on with their students at home. Two participants dropped out of university. The combination of stress at home and studying was too much for them.

> That I quit my studies did have to do with him [partner], although it was not the only reason. I couldn't take it anymore. I didn't have the energy to study anymore.
>
> (P4, 2nd interview, woman, 21yo)

Some participants experienced study delay due to missed internships.

> I got a message that we were allowed to go on an internship despite COVID-19, but I could barely get out of the house to do some shopping. Being around other people was a real drama for me. So, I missed my internship as well.
>
> (P6, 2nd interview, woman, 24yo)

Some participants caught up as time went by. These participants were getting used to online education or could do a substitute

assignment instead of an internship. A few participants did not relate their study delay to COVID-19. These participants deliberately chose a gap year or a pass.

3.3 | Decrease in stress and strain

3.3.1 | Diminishing addiction problems of relatives and less social pressure

Relatives of a few participants were using less alcohol and drugs, which decreased stress on participants. These participants believe their relatives experienced less stress and therefore began to use less alcohol or drugs.

> In my environment, everyone is doing better. I don't know how. I think COVID-19 makes them calmer, and more self-caring. They have less stress. I thought it would get worse because of that boredom, but the opposite is true.
>
> (P24, 3rd interview, man, 24yo)

There were also participants who themselves experienced less stress than before the pandemic. These participants had more peace of mind and suffered less from fear of missing out. The ones who always liked being by themselves experienced less social pressure to go out or be among people. Others had been afraid of being alone before the pandemic and found that being alone was not as bad as they thought it would be.

> COVID-19 is the best thing that could have happened to me. I was forced to focus on myself. I needed that.
>
> (P18, 2nd interview, woman, 27yo)

Participants who drank or used drugs for social reasons used less alcohol and drugs during the pandemic because social events were less frequent. These participants felt more healthy. Some found the time and peace to take a walk every day, started exercising (more), took more time to cook healthy meals, and went to bed earlier.

> I was too heavy; I had been anxious about that for a long time. I started to do a lot of sports and exercise. I could not go to university and had fewer obligations, so I suddenly had time for that.
>
> (P3, 3rd interview, woman, 21yo)

3.3.2 | Studying from home

For a few participants, especially the ones not living with their relatives with addiction problems, the pandemic made college life better. These participants said their study productivity went up because there were fewer distractions, despite adjustment problems at the beginning of the pandemic. Others managed to complete their internships despite mental health problems.

> I'm at an internship for three days and everything else is online. As weird as that may sound: COVID-19 has helped me quite a bit. Before the pandemic, I was at home for one and a half years due to a burn-out, so it was quite stressful to be back in practice. Now I could plan my hours and that was ideal. I was able to complete my internship now.
>
> (P26, 2nd interview, woman, 27yo)

3.4 | Coping strategies

The way participants coped with the consequences of the pandemic influenced their stress and strain. Of the three coping mechanisms of the SSICS-model, withdrawing was the most prevalent. The vast majority of participants distanced themselves from their families during the pandemic.

> I hardly saw my mother, and that was great. I was always reluctant to go there and there was always drama when I was there. So now I use the situation as an excuse and I don't have to feel guilty about it.
>
> (P26, 2nd interview, woman, 27yo)

A few participants went to live independently from their parents. One participant broke off her romantic relationship with a partner with addiction problems. Sometimes relatives with addiction problems distanced themselves, especially parents who were afraid to get infected by the coronavirus. This had a positive effect on the participants. For a few participants, especially those still living with their relatives with addiction problems, withdrawing became more difficult because the university was no longer a place where they could escape to. By necessity, these participants had to spend more time with their relatives with addiction problems, and less time with people who 'tried to make something from their lives and were motivated'. This increased their stress.

> Going to university was something that kept me from fretting too much. It was quite a blow that I could not go to university anymore.
>
> (P5, 3rd interview, woman, 26yo)

Instead, these participants responded by standing up or putting up strategies. A few stood up by getting angry or trying to refrain the relative from using substances. A few tried to put up and accept the situation as it was.

> I try to respond very calmly. If I stay calm, chances are my mother does too.
>
> (P28, 3rd interview, man, 20yo)

A small minority of the participants put up by drinking or using drugs to numb themselves or by joining their relative in drinking or drug taking.

> I drink with him but I know that's not normal. It seems as if I don't live in reality then, that is why I do it.
> (P5, 2nd interview, woman, 25yo)

A few participants not only withdrew from their relatives but also avoided contact with study coaches or teachers. During online classes, these participants did not turn on their cameras so the teacher could not see that they looked not well and did not ask questions. These participants tried to be literally and figuratively invisible.

> I am very good at building a wall and showing what I want to show and not the pain, or what is really going on. Hence, I am also very good at avoiding the study coach or teacher. That's even easier now, while the university is closed.
> (P10, 3rd interview, woman, 26yo)

3.5 | Access to professional and social support

Before the pandemic, some participants received informal support from family and friends. Sometimes these participants talked about their experiences with family and friends, sometimes they escaped a stressful situation at home by going to someone else's, and sometimes the presence of others was a distraction. Some received professional support from therapists, teachers, and study coaches. The pandemic generally made both social and professional support harder to access.

Informal support opportunities diminished due to social distancing measures. This hit those who lived with their relatives and those with pre-existing mental ill health the hardest. Although in the Netherlands during the pandemic one was allowed to go for a walk, visiting others in their homes was discouraged. This left participants more at home than they wanted to be, feeling lonely and sometimes desperate.

> My friends kept well to the measures, so I couldn't go there. I stayed in my room as much as possible to avoid the drinking of my mother and stepfather.
> (P30, 2nd interview, woman, 22yo)

Many participants had attended therapy before the pandemic, in most cases Eye Movement Desensitisation and Reprocessing (EMDR), cognitive behavioural therapy (CBT), or a combination of both.[2] CBT sessions generally continued satisfactorily online, providing a relationship with a therapist had been established and private conversations online were possible. Private conversations were difficult to organise for those who lived with their relatives.

> I had an intake by phone and then we switched to online chatting and video calling. I think it would have been better if I had face-to-face therapy because we had private conversations. At home, I have to watch my volume and my language, otherwise, they can hear everything.
> (P28, 2nd interview, man, 20yo)

At the beginning of the pandemic, the EMDR of some participants was stopped. After some time, EMDR was offered online but participants were not positive about these sessions, due to lack of physical contact and difficulties in concentrating on the implementation of the therapy. When the COVID-19 measures were eased, most therapies of the participants were offered face-to-face again, but in the meantime, waiting lists for those who had not yet started EMDR had grown much longer. The pandemic gave participants space to reflect on their lives, which meant some decided to start therapy.

> Maybe that's a good thing from COVID-19, that I have a lot of time to think about things like my past. I realized it's time to do something with it.
> (P9, 3rd interview, man, 26yo)

Support from teachers and study coaches came about less naturally than before the pandemic. Teachers were less able to see if a student was not feeling well, and therefore less likely to ask them about it. Their attendance during lectures was also less easy to monitor because many students turned off their cameras. Students who were in trouble could quite easily remain unseen.

> At university, they can see it if you don't look good and ask about it. That didn't happen online, especially since many students had their cameras off.
> (P30, 3rd interview, woman, 23yo)

But even when a teacher did manage to see online that a student did not fare well, this did not always result in support.

> During an online lesson, the teacher asked me: 'Is everything okay?' I said, 'Yeah, I'm fine' and then he said, 'Are you sure?' and I saw the faces of the other students looking at me on the screen and then I shut my laptop and kept it shut for three weeks.
> (P6, 2nd interview, woman, 24yo)

4 | DISCUSSION

Our study explored the impact of the COVID-19 pandemic on stress, strain on health and study experiences, coping strategies, and access to support for students with relatives with addiction problems. How the pandemic impacted these participants' lives was considerably heterogeneous due to individual and contextual factors.

Participants who lived in the same house as their relatives with addiction problems were hit hard by the pandemic. These participants experienced more stress, such as violence, and strain on health and study than participants who lived without them. They were less able to cope by withdrawing from problems at home because of social isolation measures. These participants described the university as a safe haven, which, however, could not be accessed during the pandemic at times of university closures. They also had less access to social and qualitative (online) support.

These contextual factors add to the literature on stress and strain on family well-being during the pandemic (Fong & Iarocci, 2021). Several previous studies describe an increase in the incidence of family violence during the pandemic (Boserup et al., 2020; De Klerk et al., 2021; Liu et al., 2020). In the Netherlands, the number of recorded domestic violence reports in 2020 was slightly lower than that of 2019, most likely because professionals who often report violence (e.g., social workers, teachers, and GPs) had less contact than usual with families at risk (De Klerk et al., 2021). Some organisations in the Netherlands did report a rise in child abuse and sexual violence during the first lockdown (Van Gelder et al., 2021).

In our sample having mental ill-health before the pandemic was associated with more mental health problems, especially early in the pandemic. Young adults in general are at high risk for loneliness and mental health problems (Lee et al., 2020; McGinty et al., 2020). In our study, relatively more women than men reported intensified mental health issues, especially early in the pandemic. Gender differences in mental health due to COVID-19 have been established before, with women reporting more problems (Fruehwirth et al., 2021; Gobbi et al., 2020). Participants who lost a close relative due to addiction problems before the pandemic also reported more mental health problems than before the pandemic. This has not been reported before. With the longitudinal design of our 3-year study, we could determine that mental health problems were not stable during the pandemic but fluctuated and sometimes decreased as time went by.

Some participants—especially those who labelled themselves addiction-prone—used more alcohol and/or drugs, notably at the beginning of the pandemic. Later on, during COVID-19, their substance use fluctuated and these students kept on struggling with their substance use. Substance use of AFMs who drank or used drugs socially before the pandemic decreased or remained stable over time. Other studies found that university students drank more alcohol and consumed more cannabis at the beginning of the pandemic (Ahmed et al., 2020; Gritsenko et al., 2021; Horigian et al., 2021), while longitudinal studies showed that substance use remained relatively stable over the course of the pandemic (Hawke et al., 2021; Sylvestre et al., 2022). A few participants coped by increasing their own substance use, to join their relatives in using alcohol and/or drugs. Participants rated this coping strategy negatively and as non-helping. Future research should include motives for substance use in students to identify distinctive risk groups to which support and policy programs can be targeted.

Concerning study experiences and especially study delay it appears to be difficult to determine exactly how many students in the Netherlands experienced study delay during the pandemic because higher education regulations were temporarily relaxed. Deadlines were pushed back to minimise delay. In Dutch higher education, institutions are required to issue "binding study advice" to their first-year students. Binding study advice is a decision by the university whether or not a student can continue his or her studies. That advice can be negative and the student will then have to discontinue his or her studies. During the pandemic, the Minister of Education decided to postpone the issuance of a negative binding study advice by 1 year. It needs more time to determine exactly what the impact of the pandemic on study success and study delay has been. Still, in 2021, about 30% of students in higher education in the Netherlands reported study delay due to COVID-19 (Dutch Inspectorate of Education, 2021).

4.1 | Strength and limitations

This is the first longitudinal qualitative study to examine the impact of the COVID-19 pandemic on students with relatives with addiction problems. The study sample was diverse in terms of gender, study programme, study year, relatives' type of substance use, and relationship with the relative. Participation rates were high; 93% participated in at least two interviews. One study limitation concerns possible selection bias. Participants first selected themselves by providing contact details for further research, possibly resulting in the inclusion of those who strongly identified themselves as AFM. Second, participants were predominantly of Dutch ethnic origin, while the RUAS student population is more diverse. Attempts to include participants from other cultural and ethnic backgrounds were not successful.

4.2 | Recommendations

Several recommendations can be formulated based on our results. First, policymakers and university managers must consider the unique needs of families with addiction problems as they take measures to mitigate the health impacts of a pandemic. School closures carry high social, educational, and economic costs, with severe consequences for individuals in vulnerable positions, and their families (De Klerk et al., 2021; Unesco, 2020; Van Lancker & Parolin, 2020). Students with relatives with addiction problems are such a group at risk. Discussions concerning the impact of the closure of institutes such as schools on the spread of the coronavirus reveal mixed results (Matzinger & Skinner, 2020; ONS, 2020; Rozhnova et al., 2021). Yet, our results indicate that students at risk in the home situation need a safe haven such as schools and universities because of the neutral nature of such institutions. Emergency shelters can also serve this purpose, but such shelters are likely to be perceived as stigmatising and therefore not attended. Second, we advise training for

professionals in health and educational institutes to raise awareness about what the impact of a pandemic and/or lockdown might be on the lives and health of students with relatives with addiction problems. It is important that these professionals, when in the middle of a pandemic, do not lose sight of those who are at high risk of violence and distress at home. Teachers and study coaches should actively inquire with all their students how things are going at home, assessing distress and violence. These professionals must ensure that conversations are conducted in a private setting, should be able to respond sensitively and non-judgemental, and validate the experience of students with relatives with addiction problems. They could discuss options and services available. When in doubt they should consult an expert in the area. Generally, the same holds for healthcare professionals. Healthcare professionals who are in a position to identify safety risks or abuse can encourage disclosure, give advice, initiate support, and refer to specialist services. Third, it is recommended to investigate whether students from diverse cultural and ethnic backgrounds would be willing to cooperate in research into the experiences of family members of people with addiction problems if a researcher is from their own cultural or ethnic group.

5 | CONCLUSIONS

The impact of the COVID-19 pandemic on students with relatives with addiction problems varied greatly. For the ones living with their relatives, many negative effects of the pandemic came together. These participants experienced severe stress, especially violence, were least able to withdraw from a problematic home situation, were less able to study online from home when the university was closed, and missed university as a safe haven. Also, diminished social, professional, and educational support hit this group the hardest.

AFMs with pre-existing mental health problems and/or substance use problems of their own—regardless of their living situation—were more likely to report deteriorating health, increased substance use, negative study experiences, and study delay. This was especially true for women, the ones living with their relatives, and participants who had lost a close relative because of addiction problems.

Contact with relatives was limited by governmental social distancing measures, which helped reduce stress and strain for some, especially the ones who lived independently from their relatives.

Mental health problems fluctuated and sometimes decreased as time went by. For some, the study delay that occurred at the beginning of the pandemic diminished. Some participants caught up as time went by.

It is recommended to keep schools and universities open during pandemics, offering a safe haven for students at risk in the home situation.

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CONFLICT OF INTEREST STATEMENT

The authors have declared that they have no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study (interview transcripts) are not publicly available because they contain information that could compromise the privacy of research participants but are available from the corresponding author (DvN) upon reasonable request.

ETHICS STATEMENT

This study protocol was reviewed and approved by the Faculty of Health, Medicine, and Life Sciences Research Ethics Committee of Maastricht University (approval number FHML-REC/2020/094). Participants were assured of confidentiality and informed (verbally and in writing) about the goal of the research and the procedures (voluntary participation, anonymity). All 30 participants provided written informed consent. Data were processed anonymously.

ORCID

Dorine M. van Namen https://orcid.org/0000-0001-7635-9296

ENDNOTES

[1] Psychological or physical dependence (or both) on the use of alcohol or other drugs; sometimes applied to behavioural disorders, such as sexual, Internet, and gambling addictions (APA, 2023a).

[2] In EMDR, patients are repeatedly, systematically and in a controlled manner exposed to memories of the traumatic events, while generating one of several types of bilateral sensory input, such as side-to-side eye movements or hand tapping (Hoeboer, 2022; Shapiro & Laliotis, 2015). CBT is a psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders, and severe mental illness. CBT therapists emphasise what is going on in the person's current life, rather than what has led up to their difficulties. A certain amount of information about one's history is needed, but the focus is primarily on moving forward in time to develop more effective ways of coping with life (APA, 2017).

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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