2023

Factors Leading to Alcohol Relapse During the COVID-19 Pandemic

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Walden University
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Abstract

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by

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MS, Walden University, 2015

JD, Touro College, 2000

BA, Adelphi University, 1993

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

May 2023

Abstract

Little research has been conducted exploring contributing stressors from the COVID-19 pandemic that may have led to alcohol relapse among individuals diagnosed with alcohol use disorders (AUDs). Prior to the pandemic, alcohol use was at an all-time high; during the pandemic, the rates of substance use rose significantly more. AUDs are a leading mental health problem with over 32.6 million meeting diagnostic criteria in the United States. This study was conducted to explore self-identified factors leading up to relapse during the COVID-19 pandemic among individuals diagnosed with AUDs, with a focus on the circumstances and events leading up to relapse. This qualitative study included six participants, three male and three female, from whom data were collected. Drawing upon Marlatt and Gordon's relapse prevention model as a theoretical foundation, interview data were assessed using an interpretive phenomenological analysis to identify themes in the causes for participants' relapses. Major themes were identified as phasic responses, tonic processes/proximal risks, and intrapersonal factors. The findings of this study could contribute to avoidance of substance use related fallout during future pandemics and could help guide policy and governmental funding decisions in the event of another similar large-scale disaster. These results could have implications for positive social change by helping in the development of evidence-based interventions to help deter relapse, the data could be used to guide future legislation on essential businesses in the event of a lockdown, and the findings might be useful in determining the allocation of resources to combat the side effects of another large-scale disaster.

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Dedication

Going through this academic journey has been very trying for me individually, but unfortunately it does not end there, this process has been a sacrifice on not just me and my time, but also to my family. I dedicate this writing to my oldest son Robert, my daughter Isabella, and my youngest son Michael. Thank you for all your love and understanding throughout this process. Without your support and encouragement, I would never have been able to endure this journey. Most importantly, I wish to dedicate this study and my ultimate graduation to my loving wife Dawn Marie, your encouragement empowered me with the strength, endurance, and faith to complete this journey.

Acknowledgments

To my mother and father, thank you for all your support and confidence in me. To my dissertation committee chair, Dr. Benita Stiles-Smith, thank you for not giving up on me: You truly served as the light end of the tunnel when I thought I could no longer continue. To my committee member, Dr. Yolly Zentella, thank you for insight, guidance, and support throughout this research project.

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Chapter 1: Introduction to the Study

Introduction

Alcohol use disorder (AUD) is identified by impairment to daily functioning indicated by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2022). AUDs are considered a mental health disorder denoted by criteria from four key areas: (a) impaired control, (b) social impairment, (c) risky use, and (d) pharmacological criteria (American Psychiatric Association, 2013). Alcohol relapse is viewed as an ongoing process (Witkiewitz & Marlatt, 2004) as opposed to an event. *Relapse* is a "sequence of maladaptive responses to internal or external stressors" (Chauhan et al., 2018, p. 73) that results in use of a substance. In this study, I focused on alcohol as that substance. Researchers have identified causes for relapse, such as undesirable life events, monetary loss/problems, marital conflict, family conflict, trouble at work, personal injury/illness, and family illness (Praharaj et al., 2018).

For individuals looking to maintain sobriety, 43.4% of those who did not seek help in the form of outpatient treatment or self-help, such as Alcoholics Anonymous, have relapses in the short-term (Moos & Moos, 2006). Those who attempt to maintain sobriety without professional help have a 57% relapse rate in the short-term (Moos & Moos, 2006). Gordon Alan Marlatt developed the relapse prevention (RP) taxonomy for assessing contributing factors and preventing alcohol relapse. Marlatt utilized a social cognitive behavioral model (Hendershot et al., 2011; Larimer et al., 1999) to categorize different processes, risks, and responses found to be contributing factors to relapse. These

factors include distal and proximal risks and tonic and phasic responses to assess relapse processes. Tonic processes include personality, genetics, family, and relationships (Hendershot et al., 2011) and are made up of distal and proximal risks. Distal risks are stable potential risks, such as family history or lack of social support, while proximal risks are transient in nature, such as loss of a job, relationship difficulties, or stressful life events (Witkiewitz, 2011). Phasic factors include cognitive and affective responses (Grace, 2000; Hendershot et al., 2011).

COVID-19 was identified as a global pandemic on March 11, 2020, by the World Health Organization. The results of the novel coronavirus disease (COVID-19) were serious medical ailments, deaths of more than 4.5 million worldwide, and increased mental health issues caused from the exposure (Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). Another affected area was the increase in substance use (Chiappini et al., 2020). The COVID-19 pandemic has been described as a "perfect storm" (American Psychological Association, 2021, p. 2), creating an environment filled with proximal risks that lend themselves to phasic responses and that increase the likelihood of alcohol relapses. Issues that arose due to COVID-19, such as unemployment, financial concerns, housing instability, uncertainty of the future (Dubey et al., 2020), juggling work and childcare, and disruption in daily routines (American Psychological Association, 2021; Czeisler et al., 2020), likely contributed to increased substance use. In this study I explored specific factors, as described by participants' lived experiences, that led to alcohol relapse during the COVID-19 pandemic.

In this chapter, I review the background, including the literature reviewed and the gap in that research that created a need for this study. In addition, I discuss the problem statement, which will include review of the research problem, its relationship to psychology, and the need for this study. Thereafter, I review the purpose of the study, the proposed research questions, and the framework overall. In closing, I define key terms and identify assumptions, limitations, and the significance of the study.

Background

Many studies have been conducted to identify generic causes of alcohol relapse. Researchers have explored genetic risk, coping ability, self-efficacy (Praharaj et al., 2018), high-risk situations (Larimer et al., 1999), emotional dysregulation (Ottonello et al., 2019), and emotional turmoil (Chauhan et al., 2018) and found these factors to have significant effects on relapse episodes. In addition, considerable evidence indicates that large-scale disasters result in increased substance use (Gulliver, 2014; Keyes et al., 2012), as was the case in the wake of Hurricane Katrina (Moise & Ruiz, 2016), the 2004 Florida hurricanes (Fullerton et al., 2013), the Oklahoma City bombing (Pfefferbaum et al., 2002), and the World Trade Center attacks (Adams et al., 2016). A number of studies have documented an increase in substance use and relapse episodes connected to COVID-19 (American Psychological Association, 2021; Centers for Disease Control and Prevention [CDC], 2020; Chiappini et al., 2020; Czeisler et al., 2020; Dubey et al., 2020). COVID-19 differs in many ways from these other disasters in the length of exposure to the stressors and the compounding effects of variables, such as financial hardship, grief, and health concerns. In addition, the current literature has relied on quantitative data to

calculate increase in substance use and relapses. No studies have been conducted to explore the lived experiences of individuals with AUDs that led up to their alcohol relapse episode during COVID-19.

Shinebourne and Smith (2009) discussed the need to replace quantitatively dominated psychology research with more qualitative research, specifically in addiction. The utility of a qualitative study in this area can "demystify drug and alcohol use and replace stereotypes and myths about addiction with more accurate information that reflects the reality of substance users" (Shinebourne & Smith, 2009, p. 153). A greater understanding of the lived relapse experiences of individuals with AUD during COVID-19 is needed. Data-rich qualitative exploration of the factors that may have contributed to alcohol relapse during the COVID-19 pandemic is lacking. This study was conducted in response to this significant gap in the literature.

Problem Statement

The problem explored by this study was the cause of increased alcohol relapses in the wake of a large-scale disaster with the COVID-19 pandemic as a point of reference. More specifically, there is a gap in the literature and a need to better understand the impact of COVID-19 on individuals with AUDs who were attempting to maintain sobriety. COVID-19 created a variety of stressors and situations that have been found attributable to relapse: isolation (Chiappini et al., 2020), financial instability (Dubey et al., 2020), housing issues (SAMHSA, 2021), loss of loved ones (Jemberie et al., 2020), and health concerns (Jemberie et al., 2020). Multiple studies have involved research into contributing factors to relapse, but none have identified the specific triggers caused by the

pandemic that caused relapse. According to Penn (2021), pandemics of this scale "are not so rare" (p. 3), and most people are likely to experience an extreme pandemic like COVID-19 in their lifetime.

With the discovery of new COVID-19 variants and increased development of biological weapons, being prepared for a comparable situation in the future is necessary. Understanding the causes of relapses during a future pandemic can allow for implementation of tailored interventions and can guide policy and funding decisions in the event of another large-scale disaster that could have similar stressors and required isolation. Although researchers have investigated this issue, there is extraordinarily little or no literature on the specific causes of alcohol-related relapses post large-scale disasters, such as COVID-19. If the problem remains unaddressed, substance use and relapse rates will increase during any similar pandemic, which will have a negative impact on society and drain resources that could have been directed toward other health-related issues.

Purpose of the Study

The purpose of this study was to explore self-identified experiences of individuals diagnosed with AUDs during COVID-19, using an interpretative phenomenological analysis design to gather data regarding the factors of alcohol relapse caused by the pandemic. A comprehensive understanding of the events, thoughts, and feelings that led to the relapse experience is needed. Using Marlatt and Gordon's RP model as a framework, participants' relapse experiences during COVID-19 were explored to evaluate the factors that may have contributed to distal or proximal risks. I aimed to

contribute a greater understanding of what factors caused by COVID-19 may have contributed to the increase in alcohol-related relapses. The results of this study will help provide an understanding of self-identified circumstances that led to relapse episodes. A detailed description of the study parameters is discussed in Chapter 3.

Research Questions

The purpose of this study was to explore relapse experiences of self-identified individuals diagnosed with AUDs during COVID-19. I sought out to answer two central research questions:

RQ1: What were the lived experiences of individuals diagnosed with AUD that led to relapse episodes during the COVID-19 pandemic, as described by them?

RQ2: What were identified stressors during the COVID-19 pandemic prior to alcohol relapse?

In addition, I explored the following sub-questions:

SQ1: What events led to the participants' relapse experience?

SQ2: Were there any shifts in chronic feelings during the pandemic?

SQ3: What were the participants feeling prior to their relapse?

SQ4: What meaning did the participants prescribe to their experiences?

SQ5: What factors aided in resistance to relapse?

Theoretical Framework

In this study, I used Marlatt and Gordon's RP taxonomy as the theoretical foundation. Marlatt and Gordon's RP utilizes a social cognitive behavioral model (Hendershot et al., 2011; Larimer et al., 1999) to categorize different processes, risks, and

responses found to be contributing factors to relapse. The RP model is an ideal framework to guide this study, as the elements assessed for relapse are in line with the lived alcohol relapse experiences participants were expected to share. Through this framework, I can better explore the events and emotions that led to participants' relapses. Using Marlatt and Gordon's RP taxonomy as a guide for the current study will allow for development of interventions to contend with COVID-19 pandemic-like situations in the future, which will aid in controlling the effects attributable to the epidemic (see Mota, 2020; Yao et al.,2020) or caused by future pandemics. A further discussion of the theoretical foundation for this study is in Chapter 2.

Nature of the Study

In this study, I sought to explore and identify significant factors caused by the COVID-19 pandemic that contributed to alcohol relapses. A qualitative approach with a phenomenological hermeneutics design was selected for this study; more specifically, I used interpretive phenomenological analysis (IPA). I chose this approach because individuals who relapse do so for varied reasons: some due to self-medicating (Marlatt, 1996), others due to loneliness (Ludgate, 2021), while others do so due to emotional dysregulation (Clarke et al., 2020). To compound the complexity of the causes, there is a high comorbidity of substance use disorders with co-occurring mental health issues (Ottonello, 2019), which hinders insight and complicates trigger identification. Using phenomenological hermeneutics allows participants to share their experiences in a narrative form with little structure or guidance from an interviewer. This approach provides a deeper, richer description of participants' lived experiences, without influence

from a researcher that may be otherwise encountered using a structured interview. Phenomenological hermeneutics allows for follow-up questions to help guide or prompt causal reflections that might otherwise be glossed over. Participants were screened to evaluate eligibility, which was limited to individuals with an AUD, who relapsed during the COVID-19 pandemic. Six qualified participants (three male and three female) participated in the narrative interviews. During the interviews, I attempted to suspend all prior assumptions and immersed myself into participants' lived experiences. All interviews were digitally recorded, and after the interview, I reviewed recordings to identify emergent themes; I took notes during interviews to identify impressions, key phrases, and other conceptual factors. I repeated this process, and emergent themes were then grouped together into superordinate themes. Mau et al. (2019) used a similar approach in a study to explore substance use and relapse experiences.

Definitions

Abstinence: The act of refraining from the use of something, particularly alcohol or drugs, or from participation in sexual or other activity. In most instances, abstinence from drugs or alcohol is the primary goal of substance abuse treatment (American Psychological Association, 2022).

Alcohol use disorder (AUD): Significant adverse consequences resulting from obsessive alcohol use when an individual becomes unable to control or stop their drinking. Tolerance to greater amounts of alcohol is present over time, and withdrawal symptoms are triggered when there is an attempt to cease drinking (American Psychiatric Association, 2013).

Alcohol cravings: Physical and psychological symptoms and sensations that produce a powerful desire for alcohol (Jayawickreme et al., 2012).

Maladaptation: A condition in which biological traits or behavior patterns are detrimental, counterproductive, or otherwise interfere with optimal functioning in various domains, such as successful interaction with the environment and effectual coping with the challenges and stresses of daily life (American Psychological Association, 2022).

Medicated-assisted treatment: The use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. (SAMHSA, 2022).

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential (SAMHSA, 2014).

Relapse: A process that begins after the last treatment episode and ends when the substance is used (Marlatt, 1996) due to internal and external stressors (Chauhan et al., 2018).

Self-medication: The use of a substance to lessen the negative effects of stress, anxiety, or other mental disorders or side effects of their pharmacotherapy, without the guidance of a health care provider. Self-medication may lead to addiction and other drug- or alcohol-related problems (NIAAA, 2022b).

Sobriety: Awareness and acceptance of one's present experience and commitment to value-consistent living. (Turner et al., 2014).

Trigger: A stimulus that elicits a reaction; for example, an event could be a trigger for a memory of an experience and an accompanying state of emotional arousal (American Psychological Association, 2022).

Assumptions

There were several assumptions included in this research study. There was an assumption that the research participants would be honest about their experiences. Another assumption was that participants would accurately recall the events that led to their relapses. These assumptions were necessary because each participant was providing their personal experiences that led to relapse; these experiences will describe events, thoughts, and feelings that could not otherwise be verifiable. A third assumption was that participants would have an established level of insight to be able to identify events, triggers, or emotions that preceded their relapse event. This assumption is needed to ensure the data provided is accurate and not skewed by defense mechanisms such as denial, rationalization, or minimization. I used a narrative approach coupled with prompts in the semi-structured interview design to provide an environment for causal reflection that allowed for rich data and a fulsome understanding of the phenomena. The final assumption of this research study was that I would suspend all preconceived theories as to why increases in relapses have occurred during the COVID-19 pandemic and that the data would provide a clear understanding of causes of relapses through the lived experiences of participants and address the research problem and questions. This assumption is critical in an IPA methodology, in that the assumption allows for the data

to be uncorrupted, as provided by the participant, and not altered by the inquiries themselves.

Scope and Delimitations

The scope of this research study was the exploration of the unique experiences that led to alcohol relapse during the COVID-19 pandemic among individuals diagnosed with AUDs. To say COVID-19 stressors caused relapse is too broad an assertion; specific factors need to be explored and assessed to guide policy decisions so precise interventions can be developed in the event of another pandemic. The data gained can be used to develop an understanding of contributing factors that lead to relapse and allow for development of specific interventions to help individuals maintain sobriety. The purpose of using IPA was not to gain results generalizable to all populations, but to conduct a deep exploration that may be applicable to studies with similar populations. Due to the nature of this study and the use of purposeful sampling, the data collected in this study were not intended to be transferable to all populations.

Limitations

One limitation of this study was the small sample size and the transferability of the findings to a larger population. Smith and Osborn (2007) described the use of a small sample size in exchange for a more detailed account of the lived experience; the breadth of the data obtained is exchanged for its depth. Smith (2007) described that IPA studies can be done with as few as one participant but recommends that for "students doing IPA for the first time, three participants are a useful number for the sample" (p. 56).

Accordingly, the transferability of this research is limited, but this study was designed with this limitation in mind, and the goal was data-rich exploration.

A second limitation was fully understanding how participants cope with triggers and risk factors. I used a narrative interview approach for data collection, but semi-structured interview questions were used to prompt exploration of topics briefly discussed or not brought up by the participants, such as resilience, protective factors, faith, and family systems. In addition, the data obtained were derived solely through participant self-report; as such, the study is limited to the extent that the participants were good historians and have a level of insight that allowed for recollection of relevant and significant factors that preceded relapse. Smith and Osborn (2007) discussed that participants are the experts in their lived experiences. This perceived limitation relates to securing data from participant experts. Smith and Osborn (2015) discussed limitations of securing information from participants, as their ability to linguistically convey their experiences, feelings, and emotions can be complicated and therefore result in erroneous or unconveyed data. Semistructured interviews were used to further explore topics.

A final limitation of this study was the potential for researcher biases. At the time of this study, I was the clinical care coordinator for a substance use counseling department. In this position, I worked with hundreds of patients during COVID-19; and preconceived notions of contributing factors had been previously contemplated. Biases such as these can affect dependability, thereby causing other researchers to make alternate interpretations of the data. IPA encourages the use of bracketing to suspend

these biases. In addition, I kept a journal throughout the research process to allow for reflection and to control biases.

Significance

With this study, I sought to conduct research that contributes to a better understanding of the effects of a long-term pandemic on an individual's ability to maintain abstinence from alcohol. Researchers have identified that the COVID-19 pandemic and the related required isolation caused increases in anxiety and depression, stress related to health concerns, financial and housing stability, grief related to loss of family and friends, and inaccessibility of social support. The goal of this study was to address the research questions by exploring the events that led up to relapse episodes and participants' self-identified most significant contributing stressors. This approach allowed me to explore self-identified and unrealized factors, as guided by Marlatt and Gordon's RP model. Interpretation through IPA of these aspects of participants' lived experiences aided in identifying how COVID-19 mediating variables may have played a role in participants' relapse experiences.

This study was conducted to address a gap in the literature; no other study has assessed relapse during COVID-19 from this perspective. In addition, Smith and Osbourne (2007) identified the gap that research involving addiction should be less quantitative and more exploratory. Accordingly, by securing a qualitative understanding of what individuals with substance use disorders contended with during the pandemic, I helped to address the lack of research in this area. This research has both clinical and policy implications. With this deep comprehension of the thoughts, feelings, and

emotions resulting from the pandemic, targeted interventions can be developed. In addition, this research may help guide governmental funding to help combat the potential mental health ramifications caused by future pandemics or other similar large-scale disasters. A better understanding of these experiences and how they have impacted relapses is vital.

In addition to the gap in the literature this study was conducted to help address, the data derived from this research adds to the qualitative literature on this phenomenon. Smith and Osborn (2007) highlighted behavioral scientists' proclivity to use quantitative and experimental data. Here the circumstances were new and complex, which lends themselves to the qualitative exploration of the lived experiences of individuals with AUD who relapsed during COVID-19. Furthermore, I used IPA as a methodology and implemented bracketing, which requires researchers to suspend all preconceived judgments. This approach allows for exploration guided by participants' narratives to avoid premature conclusions (Smith & Shinebourne, 2012) based on previous relapse studies (Ludgate, 2021; Ottonello, 2019; Praharaj, 2018) not focused on stressors related to COVID-19.

The findings of this exploratory study has potential implications for positive social change such as enabling governmental entities to provide funding to specific areas to help counter stressors and reduce alcohol relapses in the event of another long-term disaster. In addition, the findings may serve to develop evidence-based interventions to contend with issues caused by circumstances like that of COVID-19. Funding and interventions designed to combat precise triggers for alcohol relapse may reduce mental

health and alcohol use related health problems and could allow for real-time hands-on management of situations, as opposed to the reactive approach employed during the COVID-19 pandemic.

Summary

I conducted this qualitative study to gain a better understanding of the lived experiences of individuals with AUDs during the COVID-19 pandemic. The goal was to develop a deep understanding of thoughts, emotions, or events that lead to alcohol relapses. I sought answers to two main research questions:

RQ1: What were the lived experiences of individuals diagnosed with AUD that led to relapse episodes during the COVID-19 pandemic, as described by them?

RQ2: What were identified stressors during the COVID-19 pandemic prior to alcohol relapse.

I used the theoretical work on RP to guide the study. Six participants were included, and purposive sampling was used to narrow down eligible participants who met criteria to provide narratives. Based on the participant pool, results have limited transferability. I chose a qualitative approach in search of a deeper understanding of the phenomenon as opposed to results that could be generalizable to a larger population. While there is significant literature on causes of relapse and on mental health effects, including substance use, in the aftermath of a disaster, COVID-19 offered variables that had not yet been explored.

This study was conducted to address a gap in the literature regarding self-identified events that led to relapse. The study was designed to avoid applying previously

identified causes of relapse broadly to the circumstances surrounding COVID-19. I suspended judgment as the researcher and allowed participants' narratives to direct the exploration, thus gaining a deeper understanding of what the participants thought and felt prior to alcohol use. This information has both clinical and policy implications in that the data can be used to develop tailored interventions and to guide funding in the event of a future pandemic. This could allow for proactive programs as opposed to the reactive circumstances that occurred during the COVID-19 pandemic.

In Chapter 2, I review the most recent relevant literature regarding contributing factors to alcohol relapse, the effects of large-scale disasters on mental health and substance use, the effects of COVID-19 on mental health and substance use, and the criteria for AUD. In addition, I present a comprehensive exploration of the RP model that served as the theoretical model for this study. Chapter 2 closes with an explanation of the need for public health preparedness and how filling the gap with this research can help develop interventions and guide social policy in the event of another pandemic or other large-scale disaster.

Chapter 2: Literature Review

Introduction

Although not always seen this way, substance use and relapse is a multifaceted construct affected by biological, psychological, and social factors (Chauhan et al., 2018) that interact with an individual's responses to high-risk situations (Marlatt, 1996). Responses to high-risk situations and the potential for relapses are further complicated by mental health issues and significant world events, such as disasters like the World Trade Center attacks, Hurricane Katrina, the Oklahoma City bombings, and most currently the COVID-19 pandemic. This study focuses on contributing factors that played a role in participant alcohol-related relapses during the COVID-19 pandemic. More specifically, the purpose of this study was to explore self-identified experiences during COVID-19of individuals diagnosed with AUDs, using an IPA design to gather data regarding the factors of alcohol relapse caused by the pandemic. Alcohol use in the wake of the pandemic has risen significantly, and a comprehensive understanding of the contributing factors to relapse is needed.

AUD diagnoses have been at an all-time high; 32.6 million people in the United States have an AUD (SAMHSA, 2011). Understanding the variables that play a role in relapses is crucial and has been extensively researched in the past; however, regional/worldwide disasters are occurring more frequently. Accordingly, understanding how these events affect relapse variables needs to be explored further to help develop interventions to contend with subsequent fallout. In relation to COVID-19, Mota (2020) and Yao et al. (2020) described the mental health issues and increase in substance use as

the epidemic within the pandemic. COVID-19 began to wreak havoc in 2020 (Dubey et al., 2020) and has persisted in the years that followed: several variants have emerged, and positivity rates exceeded one million per day. Nonetheless, additional concerns are the pandemic's subsequent effects, including AUD relapses. Understanding how the pandemic, social isolation, health concerns, bereavement, and other COVID-19 related factors affect mental health needs to be assessed so that healthcare professionals can be prepared to evaluate risks and contend with the issues in a proactive manner should another pandemic or other event occur and cause similar stressors (Chiappini et al., 2020).

In the following sections, I present the strategy used for the literature review, then a review of the literature that addresses AUDs, theories of alcohol abuse, COVID-19, and the effects of other large-scale disasters on sobriety. It is through this review of the literature that I was able to identify the gap in the research, thus identifying the need for this study. Also in this chapter, I provide an exhaustive review of Marlatt and Gordon's cognitive behavioral model of RP, which was a framework to provide structure for analysis of the data collected.

Literature Search Strategy

All searches for literature were conducted through Walden University library, using the EBSCO Discovery service. Boolean searches were conducted using variations of the following keywords: *SUD, substance use, substance use disorders, relapse, alcohol, AUD, quarantine, COVID-19, SARS-CoV2, pandemic, addiction, behavioral addiction,* and *disaster*. Search results were limited to peer-reviewed articles and

scholarly journals. Additionally, I searched for articles using Google Scholar and several government websites, including CDC and SAMHSA. In the current study, results dated back 5 years and included peer-reviewed journal articles and books. Search parameters were increased beyond 5 years for topics that had limited literature, including effects of disasters such as 9/11 attacks, Oklahoma City bombings, Hurricane Katrina, and crash of Swissair Flight 111. A few leading newspaper reports related to COVID-19 and addiction were also included where appropriate.

Once articles were identified as potentially relevant, abstracts of articles were screened to evaluate the value added to the literature review. Thereafter, full texts were read to determine if data and/or authors' points of view could be incorporated into a compilation of prior study summaries. Lastly, all used articles' reference lists were reviewed to see if any additional articles could be incorporated into this literature review.

Causes of AUDs have been thoroughly researched and reviewed. Additionally, the effects of COVID-19 and subsequent stressors have been assessed and documented and clearly demonstrate an increase in adverse mental health issues and increases in substance use. Notwithstanding, few researchers have studied the specific processes in which COVID-19 and subsequent stressors have caused these increases. The following is a discussion of the theoretical framework and related topics that may play a role in this study.

Theoretical Foundation

Relapse Prevention Model

Marlatt and Gordon developed the leading approach to classifying contributing factors that lead to relapse (Chauhan et al., 2018). Their model, which was introduced in 1985, utilizes a social cognitive-behavioral model (Hendershot et al., 2011; Larimer et al., 1999) to categorize different processes, risks, and responses found to be contributing factors to relapse (Witkiewitz & Marlatt, 2004). When introducing the RP model, Marlatt (1996) reported that the disease model of addiction was the accepted theoretical model of relapse, and relapses were solely thought to be related to internal factors, such as cravings, withdrawals, and loss of control. However, RP theory posits that urges and cravings occur as a reaction to a psychological state or exposure to an environmental stimulus (Larimer et al., 1999). Prior to Marlatt (1996), several other studies (Hore, 1971; Litman1977) had begun to introduce exogenous factors in relation to relapse. Marlatt claims to have used the title of *relapse prevention*, rather than the preferred title (now the subtitle) of *maintenance strategies in treatment of addictive behaviors* because the preferred title would not have been accepted by therapists in the treatment field.

Marlatt described relapse as a process that begins after the last treatment episode and ends when the substance is used because of internal and external stressors that cause an individual to use substances to cope (Larimer et al., 1999). Two distinctions that Marlatt highlighted in his body of work are that the use of alcohol was not the occurrence that signified relapse, but that the use of alcohol was the end of a relapse event. Marlatt indicated that the relapse process began before the use of alcohol and is the result of

"apparently irrelevant decisions" (AIDs; Larimer et al., 1999, p. 154). Marlatt coined these as AIDs and indicated that a person is not aware a decision is related to a potential future relapse. Nonetheless, the decision serves to move them closer to a drinking episode. In addition, Marlatt identified three significant stages of attempted abstinence: lapse, relapse, and prolapse. *Lapse* represents the initial slip in sobriety (Ludgate, 2021) or return to drinking, *relapse* refers to an individual's return to pre-abstinence drinking habits and *prolapse* is represented by one's ability to maintain abstinence (Hendershot et al., 2011). Hendershot et al. (2011) expanded on these terms by indicating that a lapse is not a failure but rather a "fork in the road" (p. 2) that will allow for learning from the experience (increased self-efficacy) or a full-blown relapse. This is distinguished from the traditional dichotomous abstinent or relapse points of view (Ludgate, 2021) promoted by the then widely accepted disease model of alcoholism (Marlatt, 1996).

Marlatt identified that these processes, risks, and responses fall into two categories: immediate determinants and covert antecedents (Larimer et al., 1999). Marlatt (1996) provided the following examples of immediate determinants: "high-risk situations, a person's coping skills, outcome expectancies, and the abstinence violation effect"; and these as covert antecedents: "lifestyle imbalances and urges and cravings" (p. 151). Marlatt describes high-risk situations to include "emotional or cognitive states (e.g., negative affect, diminished self-efficacy), environmental contingencies (e.g., conditioned drug cues), or physiological states (e.g., acute withdrawal)" (Hendershot et al., 2011, p. 2).

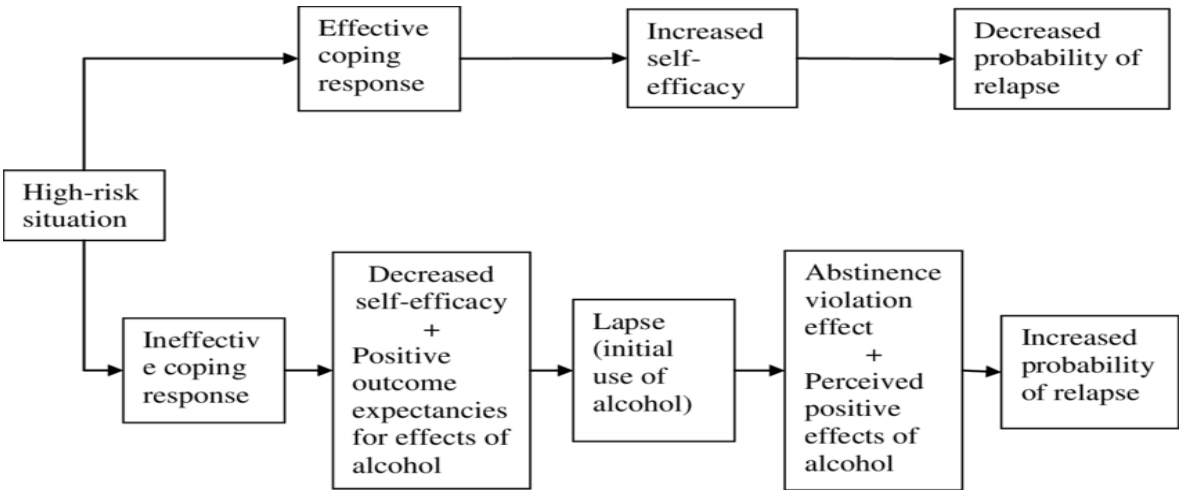
Using data from qualitative interviews, Marlatt (1996) identified categories of significant preceding events that had led to relapse. Identification was broken down into categories that included intrapersonal/environmental determinants and interpersonal determinants. Intrapersonal factors include internal factors, such as negative emotional states, motivation, coping, outcome expectancies, craving, and self-efficacy. Interpersonal factors involve another party. Marlatt (1996) expanded upon the explanation of interpersonal factors to highlight that they did not just involve another party's presence but interactions with that other party, such as social pressure, exposure to substance cues, and interpersonal conflict.

Within each category, Marlatt (1996) identified subcategories. For intrapersonal/environmental, Marlatt identified coping with frustration and/or anger (including frustration, anger, hostility, aggression, guilt, and "hassles" (p. S44) from environmental sources). Marlatt (1996) distinguished this category from dealing with other emotional states, such as fear, anxiety, tension, depression, loneliness, sadness, boredom, worry, grief, and loss. Within the second category, coping with physical/physiological states, Marlatt identified two subcategories. The first deals with physical states related to past substance use (i.e., withdrawals/cravings) and the second is coping with negative physical states not related to past substance use (pain, illness, fatigue, or injury). In the third category, Marlatt identified alcohol use in relation to desired positive effects, meaning the use was related to enhancing feelings of pleasure (i.e., to get high, to celebrate or to use on vacations). In the next category, Marlatt identified alcohol use relating to testing one's ability to drink moderately (i.e.,

willpower). In the last intrapersonal category, Marlatt (1996) identified non-substance use related urges, such as those prompted by triggers (going past a bar or finding a hidden bottle) or those occurring unexpectedly. In Marlatt and Gordon's original taxonomy, they posited that the relapse process was linear, as represented in Figure 1.

Figure 1

Marlatt and Gordon's Original Conceptualization of Relapse Prevention



Note. In Marlatt and Gordon's original conceptualization of RP, they theorized that relapse was a linear process as depicted in this diagram. Adapted from "Relapse Prevention for Alcohol and Drug Problems: That was Zen, This is Tao," by K. Witkiewitz and G. A. Marlatt, 2004, *American Psychologist, 59*(4), 224–235 (http://doi.org/10.1037/0003-066X.59.4.224).

Within interpersonal determinants, Marlatt (1996) identified three main categories: interpersonal conflict, social pressures, and enhancement of positive emotional states. Similar to intrapersonal coping stems from the same emotions (frustration and/or anger) but interpersonal coping with frustration results from

disagreements, fights, jealousy, or guilt caused by interactions with others. The second category within interpersonal coping with conflict includes all other emotions caused by interactions with third parties, such as anxiety, fear tension, worry, concern, and apprehension. The second category within interpersonal determinants is social pressures is broken down into direct and indirect pressures. Direct social pressures involve verbal interactions in which another party urges the first party to use substances. This is distinguished from instances in which the first party asks for the substances. Indirect social pressures involve the first party observing others using substances.

Response factors are separated into either tonic processes or phasic responses and into distal or proximal risks. Tonic processes indicate the individual's "chronic vulnerability to relapse" (Mau et al., 2019, p. 286) and are stable factors in one's life, whereas phasic responses are transient (Grace, 2000; Hendershot et al., 2011). Parts of the tonic processes are distal and proximal risks. Tonic processes can include personality, genetics, family, and relationships. Phasic responses are cognitive and affective in nature and can fluctuate over time, including momentary coping responses, evaluation of immediate consequences of substance use, and impaired decision making caused by current substance use. Hendershot (2011) described it as "tonic processes can determine who is vulnerable for relapse" while "phasic processes determine when relapse occurs" (p. 4).

Within tonic processes, there are distal and proximal risks. Distal risks include lack of social support, which is considered stable predispositions and can increase the risk of relapse. Proximal risks are situational and represent an immediate risk of relapse; these

are more transient in nature (Witkiewitz, 2011) and can include health impairment or injury, loss of job, relationship difficulties, or other stressful life events. Phasic responses are an individual's "cognitive, affective and physical states and coping skills utilization, which are dependent on the specific situation." (Mau et al., 2019, p. 286).

In furtherance of research related to responses, Marlatt (1996) identified several tangential factors that affect variables relating to future relapses: these include abstinence violation effect, discounting, self-efficacy, and outcome expectancy. The abstinence violation effect describes a dichotomous emotional response, the first describes individuals who attribute the use of alcohol as a personal failure, which causes guilt or shame, which in turn results in subsequent uses of alcohol (Ludgate, 2021). Alternatively, individuals who interpret the use of alcohol as an "internal factor beyond their control," i.e., an inability to maintain willpower, are more likely to abandon all attempts to remain abstinent (Larimer et al., 1999, p. 153). Marlatt distinguishes these responses from individuals who perceive relapse as an inability to cope with a high-risk situation, in that those who fall within the description of the abstinence violation effect see their use as a flaw, whereas those who see the use as an inability to cope can contemplate the ability to learn from their mistakes (Larimer et al., 1999; Marlatt, 1996; Witkiewitz & Marlatt, 2004). In sum, the abstinence violation effect posits that relapse leads to subsequent relapses. Larimer (1999) discusses the use of contracting the client to meet with a therapist immediately after a relapse, so that the episode can be explored and reframed. The purpose of this approach is to avoid the abstinence violation effect, a process that is known as relapse management.

Discounting is another factor discussed by Marlatt (1999), as well as within other alcohol use research. Discounting describes the reduced value placed on future rewards of abstinence, in favor of the immediate gratification caused by alcohol use (Larimer et al., 1999; Reyes-Huerta et al., 2018). Understanding the use of discounting and how the same can intersect with the abstinence violation effect, thereby leading to continued substance use should be considered when working with this population. Outcome expectancy describes an individual's focus on the anticipated outcome of alcohol use (Hendershot et al., 2011; Witkiewitz & Marlatt, 2004). Larimer (1999) utilizes an example of self-medication to describe outcome expectations; in their description, the individual seeks to cope with negative emotions and therefore discounts long-term goals for the immediate gratification of stress relief.

Lastly, Marlatt discusses increased self-efficacy, which is described as an individual's perceived ability to cope with high-risk situations after prior success navigating challenges while remaining abstinent (Hendershot et al., 2011). As discussed above, the use of reframing to avoid the abstinence violation effect in favor of an inability to cope with a particular situation will increase self-efficacy and will decrease the likelihood of additional relapses (Larimer et al., 1999). Complementing self-efficacy, it has been found that individuals with AUDs who are active in problem solving coping skills (vs. avoidance) can sustain abstinence for longer periods of time (Praharaj et al., 2018).

In developing his theory, Marlatt discusses the need for life-style balance (Larimer et al., 1999); he describes this factor as being a covert antecedent that if not

balanced can lead to relapse. Marlatt (1999) indicates that external demands and internally enjoyable activities, what he coins as shoulds vs. wants, need to be proportionate. A person with too many demands/stressors, or shoulds will invariably create a high-risk situation that was balanced by the rationalization that drinking is justified. Accordingly, Marlatt states that external demands need to be balanced with non-drinking "wants" to avoid relapse events (Larimer et al., 1999).

Based on Marlatt and Gordon's theory, the National Institute on Alcohol Abuse and Alcoholism launched a study entitled the Relapse Replication and Extension Project, to test reliability and validity (Witkiewitz, 2011). One criticism of Marlatt and Gordon's RP model was the notion that relapse was linear; Marlatt and Gordon's model was then reconceptualized as a multi-dimensional approach that was seen as dynamic (Witkiewitz, 2011; see Figure 2). The focus of the dynamic model was on the complex interactions between tonic and phasic processes; these include "feedback loops" (Witkiewitz, 2011, p.5) which cause reciprocal effects on cognitive, affective, and physiological precipitants (Hendershot et al., 2011).

The RP taxonomy was utilized in a study by Marlatt himself in 1996 (Marlatt, 1996) to assess high risk situations that led to alcohol relapses. The findings had two significant implications. First, the study expanded on the development of the psychological aspects of the RP model. Marlatt (1996) identifies incorporating "learning theory (operant and classic conditioning), social-cognitive psychology (outcome-expectancies, self-efficacy and attribution theory), and stress-coping research (social skills and coping skill training)" (p.S47) into his RP model. Second, the study developed

the theory that relapse is not a failure or flaw on the part of the individual, but rather an error that can be overcome. This second discovery has led to a host of interventions for those who have had a setback in their abstinence efforts.

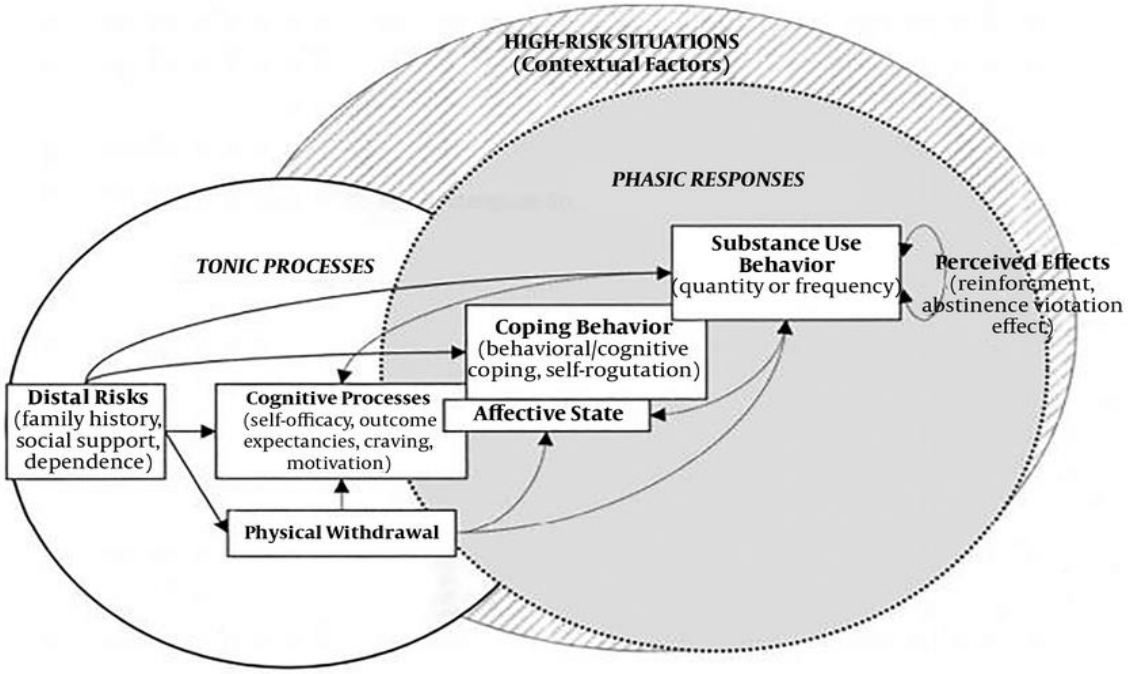
In another study conducted by Mau (2019), Marlatt and Gordon's RP model guided the researcher to inquire why patients relapse after treatment. This study was conducted utilizing qualitative interviews and an IPA, the outcome of which exposed two superordinate themes regulation of self and the role of other people. Regulation of self was overwhelmed by emotion and participants used alcohol to "regulate one's mental wellbeing" (p. 291). The second superordinate theme focused on the role of other people; participants described absence of others in their lives as well as their absences from other people's lives as a significant factor in relapse episodes.

Summary of the Relapse Prevention Framework

Ludgate (2021) summarizes those studies that have found the RP model to be effective (Larimer et al., 1999), with continued improvement and reduced intensity of relapse episodes over time. The improved dynamic model (Figure 2), which builds upon the original model, moves away from a linear approach (Figure 1) to relapse and focuses on the "dynamic and complex interactions between distal and proximal risk factors as part of a multi-dimensional system" (Witkiewitz, 2011, p. 13). Further improvements to Marlatt and Gordon's original model have included a mindfulness-based approach to RP, in which increased awareness is utilized to respond skillfully rather than react habitually to triggers (Bowen, &Vieten, 2012). The use of skillful responses lends itself to Marlatt and Gordon's lifestyle balance perspective.

Figure 2

Marlatt and Gordon's Revised Perspective of Relapse Prevention



Note. Since the development of Marlatt and Gordon's relapse prevention taxonomy, the theory has been revised to be viewed as a dynamic model, as opposed to the original linear conceptualization. Adapted from "Relapse Prevention for Alcohol and Drug Problems: That Was Zen, This Is Tao," by K. Witkiewitz, and G. A. Marlatt, 2004, *American Psychologist, 59*(4), 224–235 (http://doi.org/10.1037/0003-066X.59.4.224).

In sum, Marlatt and Gordon's theory posits that it is exposure to a high-risk situation may prompt a potential relapse, but it is the individual's response to the situation (coping abilities) that determines if alcohol is used or not (Larimer et al., 1999). Accordingly, the RP model is not a one size fits all approach (Larimer et al., 1999), but rather the high-risk situations and coping responses are specific to the individuals.

COVID-19 created a unique set of circumstances that caused unprecedented proximal risks and the potential for maladaptive phasic responses: Marlatt and Gordon's RP model is the ideal lens to analyze participant's lived experiences through. The structure provided by the RP model will allow for detailed assessment of the data obtained from the questions of what lived experiences led to relapse episodes during the COVID-19 pandemic and what stressors occurred prior to alcohol relapse.

Literature Review of Variables

The following sections pertain to additional variables addressed in the proposed study. Below I will review research on alcohol use as a mental health disorder, the criteria, additional factors used to make a diagnosis and that contribute to problem alcohol use.

Alcohol Use Disorder as a Mental Health Issue

AUD is identified by impairment to daily functioning, indicated by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences (NIAAA, 2022). Continued alcohol use has been identified as having short-term health risks, consisting of injuries (such as motor vehicle crashes, falls, drownings, and burns), violence (including homicide, suicide, sexual assault, and intimate partner violence), alcohol poisoning, risky sexual behaviors (including unprotected sex or sex with multiple partners: which can result in unintended pregnancy or sexually transmitted diseases), and miscarriage, stillbirth or fetal alcohol spectrum disorders (CDC, 2022). In addition, the CDC (2022) has identified continued alcohol use to cause long-term effects consisting of high blood pressure, heart disease, stroke, liver

disease, digestive problems, cancer (of the breast, mouth, throat, esophagus, voice box, liver, colon, and rectum, weakening of the immune system, learning, and memory problems (including poor school performance and dementia), mental health problems (including depression and anxiety), social problems (including family problems, job-related problems, and unemployment), and alcohol dependence.

AUDs are considered a mental health disorder that is denoted by criteria from four key areas, which include impaired control, social impairment, risky use, and pharmacological criteria (American Psychiatric Association, 2013). The impact of AUDs includes maladaptive behaviors such as drinking more or for a longer period than intended, inability to cut down on drinking, continued use despite intersocial problems with family or friends, cutting back on or avoiding family or social events, failing to fulfill obligations at home, school, or work, increased hazardous activities during use, cravings, or tolerance (American Psychiatric Association, 2013; NIAAA, 2022).

In the following paragraphs I will discuss statistics related to AUDs globally and in the United States as well as what criteria are utilized to assess if an individual surpasses the threshold for a diagnosis. As indicated above, AUDs are considered a mental health disorder (American Psychiatric Association, 2013), which in turn have long-term health outcomes (Sureshkumar et al., 2017). Statistics predicted 23 million people meet criteria for AUD in Europe and 32.6 million within the United States (Sliedrecht et al., 2019), while global estimates are that 100.4 million meet criteria (Moto, 2020).

According to the 2019 National Survey on Drug Use and Health (NIAAA, 2022) 14.5 million of those who responded met criteria for AUDs: 414,000 of those surveyed were within the ages of 12-17. Since the 2006 and 2014 surveys, alcohol related emergency room visits are up 47%, which equates to an average of 210,000 emergency room visits increases annually (NIAAA, 2022). It is estimated that 95,000 American people die each year from alcohol related causes: the causes include liver disease, heart disease and stroke, unspecified liver cirrhosis, upper aerodigestive tract cancers, liver cancer, supraventricular cardiac dysrhythmia, AUD, breast cancer, and hypertension (NIAAA, 2022).

Approximately 40-60% of people treated for AUDs subsequently relapse (Sureshkumar et al., 2017). The CDC (2021) reports that more than 95,000 deaths in the United States each year are attributable to excessive alcohol use: that is an average of 261 deaths per day. Alcohol contributes to about 18.5 percent of all emergency room visits in the United States. (National Institute on Alcohol Abuse and Alcoholism, 2021). The CDC (2021) estimates that alcohol related healthcare cost the nation $249 billion in 2010 alone. In 2016, alcohol was responsible for 3 million deaths, or 5.3 percent of all global deaths (National Institute on Alcohol Abuse and Alcoholism, 2021). The loss of life and toll that alcohol relapses places on the healthcare system supports the need for additional research on this subject.

Alcohol Use Disorder Criterion

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., [DSM–5]; American Psychiatric Association, 2013, p. 481) indicates that:

> All drugs that are taken in excess have in common direct activation of the brain reward system, which is involved in the reinforcement of behaviors and the production of memories. They produce such an intense activation of the reward system that those normal activities may be neglected. Instead of achieving reward system activation through adaptive behaviors, drugs of abuse directly activate the reward pathways.

Substance use disorders are assessed based on assessment cognitive, behavioral, and physiological criteria. (American Psychiatric Association, 2013). The *DSM-5* categorizes these cognitive, behavioral, and physiological criteria into four categories, including impaired control, social impairment, risky use, and pharmacological criteria.

Impaired control is refined into the first four criteria in determining if one has an AUD. Assessment includes the following: if the individual uses alcohol in larger amounts or over a longer period than was originally intended (American Psychiatric Association, 2013), if the individual expresses a persistent desire to cut down or regulate substance use or may have had multiple unsuccessful efforts to decrease alcohol use in the past (American Psychiatric Association, 2013), or if the individual spends a great deal of time obtaining the substance, using the substance, or recovering from the effects of alcohol (American Psychiatric Association, 2013), and lastly if the individual has an intense desire or urge for alcohol use (American Psychiatric Association, 2013).

The social impairment cluster of criteria includes alcohol use that has resulted in a failure to fulfill major obligations at work, school, or home (American Psychiatric Association, 2013), if alcohol use has caused a persistent or recurrent social or

interpersonal problem caused or exacerbated by the effects of the substance (American Psychiatric Association, 2013), or if important social, occupational, or recreational activities are given up or reduced because of alcohol use (American Psychiatric Association, 2013).

Cluster 3 is composed of the risky use of alcohol. This includes alcohol use in situations in which it is physically hazardous (American Psychiatric Association, 2013), and if the individual continues alcohol use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (American Psychiatric Association, 2013).

The last group of criteria encompasses pharmacological criteria with the first being tolerance which the *DSM-5* (2013) defines as a "markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed" (p.484). The last criteria is withdrawal, which the *DSM-5* (2013) states is indicated by using alcohol, or a closely related substance such as a benzodiazepine, to relieve or avoid withdrawal symptoms or any two of the following after cessation of or reduction in alcohol use that has been heavy and prolonged: (a) autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm); (b) increased hand tremor; (c) insomnia; (d) nausea or vomiting; (e) transient visual, tactile, or auditory hallucinations or illusions; (f) psychomotor agitation; (g) anxiety; and (h) generalized tonic/clonic seizures.

Criteria for AUDs are not measured by the quantity of frequency of alcohol consumed and that the criteria listed above are applicable to all substances, including

alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, hypnotics, and anxiolytics, stimulants, tobacco, and other substances. Currently, the *DSM-5* recognizes these 10 classes of substances (American Psychiatric Association, 2013).

Additional Research on Problem Alcohol Use

Although Marlatt and Gordon's theory is widely used, additional studies have focused on specific individual components incorporated in Marlatt and Gordon's RP model and on other variables that have been believed to be significant factors in initial alcohol use and relapse. Prior researchers have focused on genetic risk, coping ability, self-efficacy, and high-risk situations, to name a few. (Praharaj et al., 2018). Emotional dysregulation has been found to be a leading cause of alcohol relapse (Ottonello et al., 2019). Ottonello et al. (2019) defined emotional regulation as one's ability to identify, understand and accept one's emotional state and to utilize appropriate coping mechanisms to avoid impulsive decisions and further one's long-term goals. Marlatt ultimately refined his RP approach to one called mindfulness-based RP (Witkiewitz et al., 2005). Within the new approach, mindfulness is a key component of the cognitive behavioral approach for RP. The approach allows individuals to be in tune with current emotions, which avoids cognitive distortions and focuses on what is happening, all of which aids in undistracted emotional identification and skillful responses to stressors (Bowen et al., 2009).

Ottonello et al. (2019) not only identified the persistence of emotional dysregulation as a significant factor that leads to relapse, but emotional dysregulation as the main reason for alcohol use in general. Ottonello et al. (2019) cited that those without

emotional regulation skills tend to give into impulses to satisfy short-term urges, rather than remaining focused on long-term sobriety goals. Similarly, emotional dysregulation is the underlying cause of mental health conditions; an inability to identify, label, express, and manage emotional states will cause stress and can lead to depression, anxiety, and alcohol use (Clarke et al., 2020). Individuals need to be able to identify emotions and avoid immediate gratification seeking behaviors in favor of adaptive coping mechanisms to avoid relapse, which also lends itself to the mindfulness approach put forward by Segal and discussed above.

In a study conducted by Mau et al. (2019), they too found that individuals confronted with situations that cause overwhelming emotions used alcohol to contend with the situation. Of the individuals involved in the study, some attributed the use of alcohol as the result of long-lasting experiences that led to overwhelming emotional turmoil, while others identified a short-term recent event as the cause of relapse (Mau et al., 2019), which seems to indicate that emotional stress can play a factor when cumulative and/or intense. In either scenario, participants identified the use of alcohol to help manage overwhelming emotions (Mau et al., 2019). Emotions were an item discussed and factored into Marlatt and Gordon's RP Model, and an item discussed in his work was the finding that relapse related to emotional turmoil (anger, frustration, sadness, and anxiety) increased the likelihood of future relapses (Chauhan et al., 2018).

Mau et al.'s (2019) study also identified several other factors that should be taken into consideration for this study; first, participants reframed relapse experiences to justify alcohol use to contend with overwhelming emotions (Mau et al., 2019). This is a theme

that was supported by research conducted by Reyes-Huerta et al. (2018), in their study the researchers also identified that relapse was a result of an impulsive choice or action. In the scenario of an impulsive choice, Reyes-Huerta et al. (2018) reported that the individual discounts the delayed rewards of abstinence in favor of immediate stress relief given by substance use. Stated differently, Reyes-Huerta et al. 's (2018) study posited that impulsive action is the result of the individual's inability to control overwhelming urges. The researchers (Reyes-Huerta et al., 2018) hypothesized that either path, impulsive choice, or impulsive action, were influenced by personal biases resulting from how participants framed the choices relating to the episode or context.

In addition, participants in the Mau et al. (2019) study identified that they could not maintain longevity of sobriety by themselves but needed help of others to do so; the absence of other people was a common theme in relapse experiences (Mau et al., 2019). The circumstances surrounding COVID-19 created un-paralleled stressors and isolation, which have been described as creating the "perfect storm" (American Psychological Association, 2021, p. 2). The roles of other people were important for the individual susceptible to relapse, to not only gain support, but also for that same individual to be a positive role model for others (Mau et al., 2019). This subtheme is a central tenet in self-help groups like Alcoholics Anonymous (2013, p. 89), but Mau et al. (2019) also found that participants described the need to be a positive role model for others such as "their children, younger siblings or a partner" (Mau et al., 2019, p. 293). Additionally, the Mau study (2019) found that individuals not only needed to be in the presence of other people but needed to be understood by those who they sought support from. Each of these points

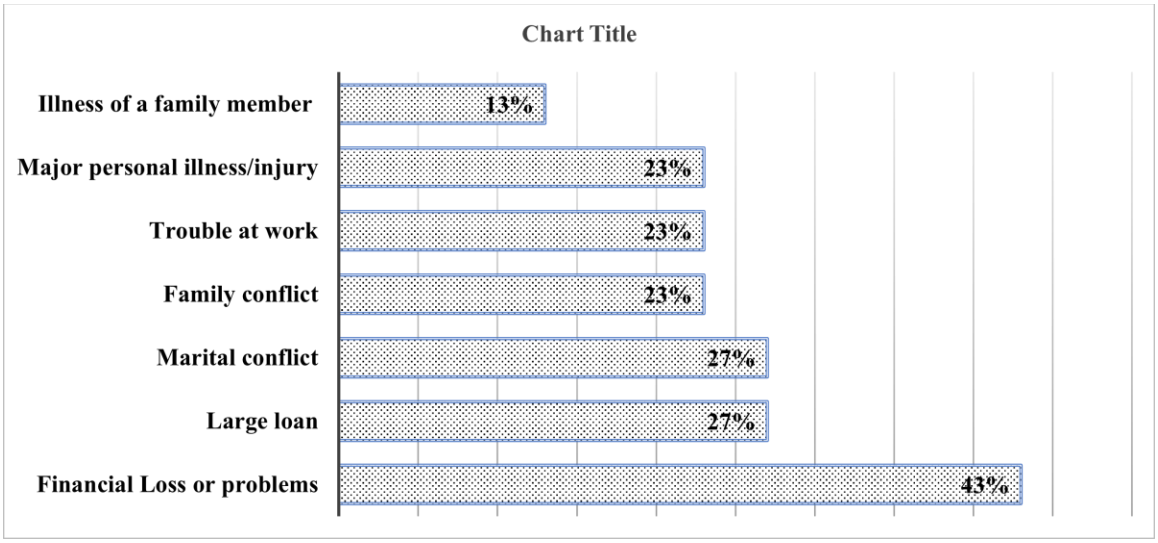
reflects that isolation can be detrimental to sobriety (Moto, 2020), that social interactions (Praharaj et al., 2018) and being understood by others were themes needed to successfully maintain abstinence (Mau et al., 2019; Sureshkumar et al., 2017).

Lastly, Mau's study identified the need for alcohol users to be around other people to set boundaries relating to alcohol use (Mau et al., 2019). Interestingly, Mau (2019) utilized an example of "comparing one's own life to what is displayed on social media" and "the individuals trying to handle difficult feelings (e.g., boredom and loneliness, alone)" (p. 293) both of which were significant issues that required navigation during the COVID-19 mandated isolation.

In another study conducted by Praharaj et al. (2018), the researchers assessed the number of stressful life events among patients with alcoholic relapse in the past year. Researchers cited previous studies in which undesirable life events were higher among those with alcohol and opioid use disorders who had relapsed than those who maintained sobriety (see diagram 3 below). Additionally, Praharaj et al. (2018) referenced a prior study in which relapse was more likely after three stressful life events. Within Praharaj et al.'s (2018) study, monetary loss/problems were the most common event among individuals that relapsed. After monetary loss, stressors related to large loans or those related to marital conflict represented the second most significant types of life events amongst those who relapsed. Thereafter, Praharaj et al. (2018) found events related to family conflict, trouble at work, personal injury, illness, and then family illness to also be themes with those that had relapsed. See Figure 3 for comparison of life event triggers. Clearly, all these factors were present and intensified by the COVID pandemic.

Figure 3

Comparison of Life Stressors' Effect on Relapse



Note. This study identified the seven most common life events that preceded relapse. Adapted from "Life Events in Past One Year in Alcohol-Dependent Patients Presenting With Relapse, by S. K. Praharaj, R. N. Munoli, and P. S. V. N., 2018, *Journal of Substance Use*, *23*(1), 99–102 (https://doi.org/10.1080/14659891.2017.1348560).

In a study conducted by Reyes et al. (2009), the authors discussed their exploration of the intersectionality of mental health disorders, alcohol use, and stressful life events. Reyes et al. (2009) reported that individuals with antisocial personality disorder were found to be twice as likely to relapse in response to life stressors compared to those with obsessive-compulsive disorder. Reyes describes that obsessive compulsive disorder served as a "protective factor from relapse" (Reyes et al., 2009, p. 230). Furthermore, individuals with antisocial personality disorder were six times more likely to relapse in response to a stressful financial event (Reyes et al., 2009).

Although conducted in 2018, prior to COVID-19, Reyes-Huerta et al.'s research (2018) discussed a salient point, which could enhance the effects of COVID-19 stressors on relapse rates. The researchers reported that discounting delayed rewards, such as health or employment, in favor of the immediate gratification of alcohol use, was shorter when rewards were open ended. Alternatively, when rewards were structured as a calendar date, discounting rates were less impactful; as such discounting rates became a linear function, thereby extending periods of abstinence (Reyes-Huerta et al., 2018). This is an aspect worth noting for the current study, as COVID-19 was without parameters as to timeframes.

In a study conducted by Chauhan et al. (2018), the researchers focused on examining "the association between demographic variables, clinical parameters, and psychosocial factors that predict the vulnerability to relapse in cases of alcohol dependence syndrome" (p. 73). Chauhan et al. (2018) claimed that individuals with AUD maintained self-control until confronted with high-risk situations. The authors categorized three situations that could lead to relapse: negative emotional states, interpersonal conflicts, and social pressures. The authors concluded that six factors emerged from the study: themes of bitterness/anger, domestic conflicts, disappointment over unfulfilled expectations, tension, unjustified punishments, and professional difficulties (Chauhan et al., 2018).

Chauhan's (2018) conclusions supported Marlatt and Gordon's model in that the study confirmed the hypothesis that negative mood states precipitated relapse. Participants described themes that supported the notion that unpleasant effects and

external events were precursors to relapse. In addition, Chauhan et al. (2018) found other factors preceding relapse were direct or indirect social pressure, cues, urge, and withdrawal symptoms.

Another commonly identified cause for substance use is mental health issues in relation to self-medicating (Sterling et al., 2011), with alcohol being one of the most common substances abused (SAMHSA 2011). The cycle of continued relapses is common among individuals with dual diagnoses (Sliedrecht et al., 2019). It is often questioned whether clients with dual diagnoses of mental health disorders and substance use disorders utilize alcohol to mask/contend with mental health issues or if mental health issues are the result of substance use.

As indicated above, mental health issues are a cause for substance use as self-medication for relief from symptomology (Marlatt, 1996). Compounding this construct, COVID-19 itself has caused a series of psychosocial stressors resulting in mental health issues, thereby increasing the numbers of individuals that are utilizing alcohol to soothe mental health symptomology.

In Sureshkumar et al. (2017) study, they found that the lack of coping skills for stressful situations, followed by exposure to high-risk situations, had the highest correlation to relapse. Other factors that have been found to be variables in relapse have been "marital status, education, and clinical factors such as the age at onset of dependence, duration of dependence, time to develop dependence, history of previous relapses, and family history of dependence" (Sureshkumar et al., 2017, p. 313). Despite

other studies to the contrary (Ludgate, 2021; Mau et al., 2019; Moto, 2020), Sureshkumar et al.'s (2017) findings reported that lack of social support was not correlated to relapse.

Marlatt created distinctions between lapse, relapse, and prolapse; Ludgate (2021) differentiates relapse similarly. Ludgate (2021) identifies relapse, or reemergence of symptoms, as occurring 6-9 months after initiation of abstinence: but when a drinking episode occurs after 12 months of abstinence it is considered a new episode, not a relapse. Ludgate (2021) offered two conflicting perspectives when discussing relapse: the first looks at relapse as a binary construct; an individual is either well (abstinent) or ill (active drinking). The second, which is in line with Marlatt's perspective, is that relapse is regression. The former see relapse as an outcome, while the latter sees it as a process (Ludgate, 2021).

Summary of Alcohol Use Disorder as a Mental Health Issue

AUD is at astounding rates nationally. In addition to problematic use, alcohol use as a vehicle to contend with negative emotions is well documented (Moto, 2020). Individuals with mental health issues, especially those who have difficulty processing feelings of emptiness and abandonment, need social support to maintain sobriety (Moto, 2020). Failure to maintain that stability can lead to an increased frequency of intoxication and alcohol consumption (Simon et al., 2020).

COVID-19 Pandemic

On March 11, 2020, the World Health Organization (WHO) classified the public health emergency known as COVID-19 as a worldwide pandemic (Cucinotta & Vanelli, 2020). Dubey et al. (2020) describe the pandemic as the "greatest public health

catastrophe of our time" (p. 817). As of September 2021, despite 5,289,724,918 vaccines being administered, Corona Virus had 220,563,227 confirmed cases and was attributable for 4,565,483 deaths (WHO, 2021); these figures are calculated as having taken more U.S. lives than those lost during World War I, the Vietnam War, and the Korean War combined (SAMHSA, 2021).

As of January 2022, COVID emerged in two subsequent variants of concern, the delta variant, and the omicron variant. (CDC, 2021b). In the United States, variants are determined to be "of interest" through an interagency coordination led by the Department of Health and Human Services. Other agencies that participate in the monitoring variants are the Center for Disease Control, the National Institutes of Health, the Food and Drug Administration, the Biomedical Advanced Research and Development Authority, and the Department of Defense (CDC, 2021b). According to the CDC (2021b), variants become "of interest" based on three factors: (a) specific genetic markers that are predicted to affect transmission, diagnostics, therapeutics, or immune escape; (b) evidence that it is the cause of an increased proportion of cases or unique outbreak clusters; and (c) limited prevalence or expansion in the United States or in other countries.

In addition to medical issues caused by COVID-19, the tangential effects of the pandemic, such as home confinement, sustained lockdown, isolation, economic stressors, and emotional reactions have caused significant negative behavioral reactions, including initial substance use and subsequent abuse/relapses (Dubey et al., 2020). Dubey et al. (2020) also identified that the circumstances caused by COVID-19brought changes in daily patterns that led to increased screen time that in turn led to decreased physical

activity, altered eating habits, and disrupted sleep habits, all of which have contributed to increased mental health and medical issues.

Gunnell et al. (2020) identified that the long-term effects of COVID-19 are more than initially anticipated. Fear, isolation, and social distancing have caused an increase in suicide statistics, and individuals with pre-existing mental health disorders are experiencing worsening symptomology, and new waves of mental health issues such as PTSD, anxiety, and depression, were experienced by those affected by COVID-19 turbulence. Contributing factors to increases in mental health and substance use disorders include fear, despair, grief, isolation, social distancing, elevated levels of exposure to illness, anxiety, depression, insomnia, instability in food, housing, employment, irresponsible media reporting (Gunnell, 2020), experiences with domestic violence, child abuse, gambling, and initial substance use (Mota, 2020) to alleviate these negative feelings.

COVID-19 in Relation to Substance Use and Mental Health

All populations have felt the negative mental health effects of the COVID-19 pandemic. This concern was identified early on during the pandemic and isolation period by Dubey et al. (2020) and others. Simon et al. (2020) identified two effects of COVID-19 on mental health, primary and secondary stressors. Primary stressors may consist of exposure to the virus and severe, even life-threatening illness, whereas secondary stressors include reduction in social contact and support due to physical distancing, loss of a job or business, or inability to pay for housing or food (Simon et al., 2020). Chiappini et al. (2020) referenced potential causes to these effects to be attributable to

fear, uncertainty, and anxiety; social distancing/isolation; loneliness; economic repercussions and instability in basic needs. These factors influenced individuals without pre-existing mental health disorders but had a much larger impact on those with prior diagnoses, including those with substance use disorders.

In December 2020, the CDC released data that substance use overdoses were at a record high (CDC, 2020). The Center identified that in a 12-month rolling period, ending March 2020, 81,000 overdoses were reported (CDC, 2020). The director of the CDC, Robert Redfield, M.D., attributed increased substance use to the pandemic's disruption to daily life and reported that those with substance use disorders had been disproportionately adversely affected by the related stressors (CDC, 2020). In addition to the disruption to routines/life caused by COVID-19 being an attributing factor to increased substance use, the CDC also attributed increased stress as a leading factor to alcohol use (CDC, 2020b).

Impact on those with substance use disorders, particularly those with AUD, may include a response to the factors listed above, a shift from other substances to the more readily available alcohol, lack of access to medication assisted treatment (MAT), and growth of minor relapses to uncontrolled use due to lack of access to self-help or outpatient support. The American Psychological Association (2021) quotes Dr. William Stoops, PhD, a professor of behavioral science, psychiatry, and psychology at the University of Kentucky, describing the COVID circumstances as "a perfect storm" causing stress and isolation and promoting unhealthy decisions to cope. This is an

opinion agreed upon by Chiappini et al. (2020), who specifically identify substance use development as due to COVID-19 related stress.

Dubey et al. (2020) listed specific COVID-19 factors that contributed to stress as abrupt unemployment, financial concerns, housing instability, and uncertainty of the future, as factors that may have affected all, but that were significant for "low-income groups like small businesspeople, migrant workers, and daily earners" (p. 818). Jemberie et al. (2020) noted that when individuals with substance use disorders "lose the structure of employment and sense of purpose" (p. 2), or as foreclosures, housing instability, or uncertainty of the future continues, mental health, substance use, and substance use symptom severity, will increase.

Similarly, the American Psychological Association has attributed increased alcohol consumption during the pandemic to related uncertainty, stress, financial instability, juggling work and childcare, and disruption in daily routines (American Psychological Association, 2021; Czeisler et al., 2020). These stressors have contributed to increased stress, anxiety, traumatic stress, and increased substance use, including alcohol (SAMHSA, 2021). Although these effects are the byproducts of the pandemic, experts raise concerns about the "second wave" (SAMHSA, 2021, p. 3) of mental health issues that will follow. The mental health risks caused by the pandemic will include increases in substance use, depression, anxiety, and suicide (Öngüret al. 2020).

In an American Psychological Association study from 2020, evaluating stress and mental health, 4,435 participants (3049 adults and 1026 teenage participants) reported increased stress (SAMHSA, 2021). This represents a 19% increase from the same survey

conducted the year prior (SAMHSA, 2021). The study was intended to measure situational distress, rather than psychopathology. Of the respondents to the survey, 78% identified COVID-19 as the source of causal stress in their lives. The research brought to light increased levels of depression, anxiety, traumatic stress, and loneliness brought about by the pandemic and related social isolation (SAMHSA, 2021).

In a similar study conducted in June 2020 by Czeisler et al. (2020), 5,412 participants were surveyed to assess mental health issues caused by COVID-19; 40.9% reported an adverse mental or behavioral health condition. The results reflected that 25.5% of the respondents' met criteria for generalized anxiety disorder, which was approximately three times the amount from a 2019 survey, showing 8.1% (Czeisler et al., 2020). Of the participants polled, 26.3% reported traumatic stress related disorder symptomology. In addition, 24.3% of respondents were symptomatic for depression, which were approximately 4 times as many as the 6.5% reported in 2019. In addition, Czeisler et al.'s study (2020) reflected that 13.3% of those surveyed had begun or increased substance use, including alcohol, to help cope with COVID-19 related stress. Lastly, 10.7% of those who participated in the study reported suicidal ideation in the last 30 days, which is more than double the 4.3% that was reported in 2019.

Another study known as the Household Pulse Study (HPS), which is conducted by the CDC and the U.S. Census Bureau, was designed to monitor the rapid changes in mental health that were happening during COVID-19. The HPS was designed to track real-time responses of strategies to combat adverse mental health effects from COVID-19, thereby allowing modification of interventions for populations affected by the

pandemic. The sampling strategy utilized a rapid response household survey that gathered data from 790,633 participants. The report tracked changes from August 19th, 2020, through February 1st, 2021(Vahratian, 2021). During the period of August 19-31, 2020, and December 9-21, 2020, the most significant increases were observed, when symptoms of anxiety increased from 31.4% to 36.9% and symptoms of depressive disorder increased from 24.5% to 30.2%. In addition, from August 19th to the 31st compared with November 25th to December 7th, 2020, increases of those reported taking medications rose 2.6%. At that time, participants reported an increase of 3.2% of those needing mental health services but not receiving counseling (Vahratian, 2021). These numbers rose further in the period covering August 19th through the 31st, 2020 to February 1st, 2021, in which individuals with anxiety and or depressive disorder symptomology increased from 36.4% to 41.5%. The result of the Vahratian (2021) study showed that the increase in mental health distress results corresponded to the number of reported COVID-19 cases during the related periods.

With the increase in mental health issues, it was understandable that substance use increased as well; Moto (2020) indicated that mental health stability is crucial to maintain sobriety. But the increase in mental health issues was not the only cause for increased alcohol use; another factor that resulted in an increase in alcohol use was the unavailability of other substances that were caused by the pandemic's travel restrictions. Chiappini et al. (2020) reported that COVID-19 impacted all street level drug markets. In discussing the shortage, Chiappini et al. (2020) indicated synthetic drug availability, such as methamphetamine, were reduced due to air travel restrictions and flight cancellations.

Similarly, marijuana was found to be less available due to border restrictions caused by the lockdown (Chiappini et al., 2020). Alternatively, in many areas, liquor access was not restricted. During the lockdown, governmental authorities deemed alcohol to be an "essential commodity" (Dubey et al., 2020, p.818). In addition, relaxation of the licensing rules was allowed. Both were allowed to compensate for a fallen economy, but this also contributed to the increase in alcohol use. (Dubey et al., 2020). New York deemed liquor stores to be an essential business, allowing for continued operation when most other businesses were required to close (New York State Liquor Authority, 2020). According to the NYS Liquor Store Association (2020), this was granted to "assist the public in getting through these challenging times." Further making alcohol more readily available than other substances, dining establishments were permitted to provide "take home liquor orders" and retail liquor establishments were permitted to provide curbside and home delivery (New York State Liquor Authority, 2020). In addition to New York, all but four states allowed liquor stores to remain open during the lockdown and all but eleven deemed off-site liquor stores to be considered an essential business. (National Institute on Alcohol Abuse and Alcoholism, 2020).

The National Institute on Alcohol Abuse and Alcoholism (2020) indicates that only five states specifically disallowed the home delivery of alcohol by liquor retailers during the COVID-19 pandemic. Similarly, all but 6 states allowed establishments with permits for on-site liquor consumption to allow liquor take-out and only eleven States specifically denied onsite consumption establishments home delivery of liquor; all others

were either granted permission or the orders relating to the lockdown were silent on the subject (National Institute on Alcohol Abuse and Alcoholism, 2020).

In addition to the availability of other drugs, which has led individuals to turn to readily available alcohol, COVID-19 has caused a rise in alcohol use and relapses due to shut down of self-help meetings, such as Alcoholics Anonymous (Chiappini, 2020). Isolation and lack of support have been found to be contributing factors to relapse (Praharaj et al., 2018). Clearly, the use of telemedicine during COVID-19 isolation was helpful, but the decreased level of engagement and human interaction was readily apparent and did not serve as a comparable replacement for in-person counseling and support of peers offered by group counseling and self-help groups.

Other research has supported these observations. In a study conducted at the University of Washington Alcohol and Drug Abuse Institute, the researchers observed a spike in substance use quantity and frequency during the pandemic (Chiappini et al., 2020). The same study reported that clients explored the use of new drugs due to limited access to their drug of choice (Chiappini et al., 2020).

One issue that is prevalent for individuals with substance use disorders is that outpatient services alone might not be enough to maintain abstinence (Chiappini et al.,2020). This issue is further complicated by the additional free time caused by the COVID-19 lockdowns. In addition to the unwanted additional free time, those impacted by the lockdowns suffered from a loss of structure (Centers for Medicare & Medicaid Services, 2021), loss of social support (Dubey et al., 2020), and loss of access to support services for mental health and substance use counseling (Chiappini et al., 2020). During

the COVID-19 lockdowns, individual's places of employment and academic institutions were closed. In addition, state and local governments encouraged residents to avoid leaving their homes. These issues caused disruptions in the structure of all people's lives, but those afflicted with substance use disorders were quite possibly impacted most severely of all.

In a retrospective analysis conducted by the Centers for Medicare and Medicaid Services (CMS) in May of 2021, the agency revealed a sharp decline in services obtained from March to October 2020 versus the same period in 2019 (Centers for Medicare & Medicaid Services, 2021). The study revealed that during COVID-19, services related to mental health and substance counseling were not sought out as frequently, as compared to the same period the year prior. The CMS study reported a 22% decrease in mental health services for Medicaid recipients from the age of 19-64; the 22% decrease equated to 12 million fewer sessions for this population (CMS, 2021). Similarly, Medicaid recipients 19 years of age and younger had a decrease of sessions attended in the amount of 34%, which equated to 14 million less sessions (CMS, 2021). Lastly, the report reflected that 13% fewer substance use counseling sessions were attended; that is a decrease of 3.6 million sessions from those attended in 2019 (CMS, 2021).

These figures are staggering in and of themselves, but two additional factors make the reflected decreases even more alarming. Firstly, during the pandemic more providers utilized telehealth to overcome in-person exposure risks. Unfortunately, telehealth is not equivalent to in person counseling, as these sessions are seen as a key therapeutic ingredient to a patient's stability/recovery (Jemberie et al., 2020). The CMS (2021)

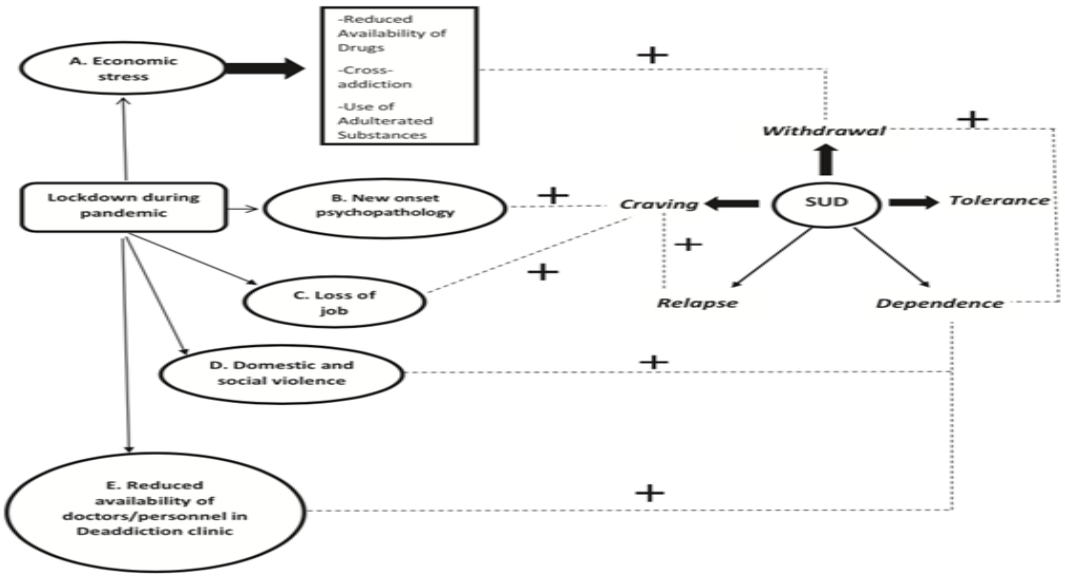
reports an increase of telehealth sessions by 2,700%, as compared to the same period in 2019. It should be noted that the decrease in session attendance considers the increase in telehealth sessions offered, accordingly had it not been for the increase in telehealth sessions the comparison to the 2019 figures would have reflected significantly higher numbers. Secondly, the decrease in sessions attended is staggering assuming the status quo in the world's environment. But when considered during a pandemic, where all studies report an increase in anxiety, depression, and substance use (Dubey et al., 2020), the figures are more confounding considering that all session percentages should have increased.

Social isolation, lack of mental health and substance use counseling services, and increased stress brought by the stress related to COVID-19, left many looking for avenues to cope and self-soothe (American Psychological Association, 2021b). With liquor stores being considered essential and allowed to remain open during the lockdown and lack of availability for other substances due to interstate and international travel restrictions, people turned to alcohol to contend with increased stressors. The use of alcohol provides temporary pleasure to users and may have/can lead to neuronal adaptations in stress, reward pathways, and stress reactivity thereby increasing cravings in stressful situations (Dubey et al., 2020). Dubey et al. (2020) demonstrated the bidirectional relation between substance use and COVID-19 in the referenced Figure 4 below. As demonstrated, substance use exacerbates the COVID-19 caused stressors, which in turn causes increased substance use cravings.

The stressors, such as anxiety, depression, and loneliness caused by COVID-19 provided an easily identifiable understanding of increased alcohol use to cope with these emotions. Other consequences of isolation that were less apparent were family disharmony caused by increased interactions due to work/school from home and the unavailability of other substances due to overseas and interstate travel constraints. These coupled with ease of access to alcohol allowed individuals with other substance use disorders to easily transition to alcohol use, a process known as cross addiction (Dubey et al., 2020). The susceptibility of an individual to switch substances is facilitated by the need for alternative substances to trigger the dopamine reward center to allow for "feel good effects" (Dubey et al., 2020, p.821). The lack of social interactions, lack of availability of self-help, limitation of medications, and lack of access to therapy has contributed to the increase of cross addiction to alcohol.

Figure 4

Perceived COVID Stressors in Relation to Substance Use



Note. Dubey et al. (2020) conceptualized the interplay of addictive behaviors with COVID stressors and the strain on support services during the pandemic. Adapted from "COVID-19 and Addiction," by M. J. Dubey, R. Ghosh, S. Chatterjee, P. Biswas, S. Chatterjee, and S. Dubey, 2020, *Diabetes & Metabolic Syndrome, 14*(5), 817–823, (https://doi.org/10.1016/j.dsx.2020.06.008).

In general, individuals with substance use disorders either do not seek out counseling or fall into non-compliance with treatment recommendations (Dubey et al., 2020). The lack of services offered or sought out during COVID-19 has caused an increase in challenges in serving this population. Further confounding this issue is the diverting of resources from substance use services to COVID related needs (Jemberie et al., 2020) and the lack of medical appointments for which individuals with addictions could secure MAT. The use of MAT aids in blocking the desired effects of substance use,

controlling urges related to substance withdrawals, and aiding in attaining balance brain chemistry (SAMHSA, 2021b). Medications such as Acamprosate, disulfiram, and naltrexone have been clinically effective in contending with AUD cravings, while buprenorphine, methadone, and naltrexone are prescribed to contend with opioid use disorders. Appointment availability for administration of the MAT was limited due to triaging the need for appointments for COVID-19 related medical needs.

Other Effects of COVID

Above we have discussed how COVID can contribute to increased substance/alcohol use, but these interactions are bidirectional. Alcohol use can contribute to increases in coronavirus contraction. COVID-19 has had a disproportionate effect on those with pre-existing substance use disorders (Jemberie et al., 2020); the intersectionality between the effects of COVID-19 (both mental and physical) and substance use disorder symptomology, has contributed significantly to increases in both diagnoses. Jemberie et al. (2020) posited five dimensions in which comorbidity between COVID-19 and substance use disorders can adversely affect one another:

First, drug and alcohol use are often communal (e.g., sharing blunts, smoking pipes, or syringes) and may contribute to the spread of COVID-19. Second, many individuals with SUD have limited financial resources, unstable housing, and limited access to clean water and soap increasing their risk of infection. Third, co-morbidities prevalent among people with SUD are associated with more severe COVID-19 symptoms, complications, fatalities and increased vulnerability to COVID-19. Fourth, COVID-19 public health mitigation measures (i.e., physical distancing, quarantine, and

isolation) may exacerbate loneliness, mental health symptoms, withdrawal symptoms, and psychological trauma. Fifth, COVID-19 mitigation measures are likely to inhibit access to SUD treatment services (p. 2).

Yao et al. (2020) indicated that people with mental health disorders are more susceptible to illness and posit that this may be attributable to cognitive impairments, lack of awareness of associated risks, diminished insight into the need for personal protection, or rates of transmittal caused by inpatient settings. Yao et al. (2020) indicates that these issues are further complicated by the challenges of this population to gain medical attention in a timely manner, if at all. Furthermore, this population is pre-disposed to subsequent mental health issues caused by pandemic related fear, isolation, and stressors (Yao et al., 2020). In addition, Moto (2020) posited that individuals with substance use disorders were subjected to cravings and triggers caused by the need to alleviate COVID-19 related negative emotions, thereby compelling them to venture out to find their drug of choice, resulting in susceptibility to contracting the coronavirus due to increased exposure. Moto (2020) also highlights those individuals with AUDs have a propensity for weakened immune systems, which can result in susceptibility to pneumonia, thereby making them more vulnerable to COVID-19.

Summary of COVID-19 Pandemic

As of March 11, 2020, when the WHO identified COVID, the CDC reported 514 new cases a day nationally (CDC, 2021c). On March 22,2020 when states began to announce mandated isolation, the CDC reported upwards of 10,000 new cases a day

(CDC, 2021c). As of December 29, 2021, the CDC was reporting 486,428 new cases a day (CDC, 2021c).

In the current situation, hospitals around the nation are overwhelmed with addressing those with health related COVID-19 symptoms. As a result, individuals with mental health or behavioral disorders were not prioritized. The impact of the effects of COVID-19 can best be described as a "multidimensional disruption of employment, finances, education, health care, food security, transportation, recreation, cultural and religious practices, and the ability of personal support networks and communities" (Simon et al., 2020, p. 1493), all of which individually can impact mental health but occur concurrently can have a confounding effect on psychological stability. Although understandable during the pandemic, it was unanticipated that COVID-19 stressors would serve as such a significant contributing variable to new and increased rates of substance use relapses. The challenge that we now encounter is contending with the increased number of individuals with substance use behaviors caused by the prioritizing of health issues. These series of events created a cycle of anxiety and depression, coupled with isolation, fear, and health related issues, that resulted in subsequent substance use, which bred additional mental health issues. In the event of another disaster that may have similar stressors, Dubey et al. (2020) recommended families monitor internet content and its usage by children, engage in family time, and physical exercise to avoid addictive behaviors.

Alcohol is one of the most frequently abused substances in the United States (National Institute on Drug Abuse, 2022). In the COVID 19 situation, liquor stores were

considered an essential commodity and a vehicle to aid a slipping economy (Dubey et al., 2020). The pre-existing predilection for alcohol use, compounded by the unavailability of other drugs and continued access to liquor has contributed to increased alcohol use. Furthermore, the use of alcohol for self-medication of mental health issues, including depression, coupled with the fact that alcohol is a depressant, created a vicious cycle of continued use resulting in worsened mental health states and then related further continued use.

To aid in combating the epidemic caused by the pandemic, the government administration provided $2.5 billion in funding in 2021, to address the nation's mental illness and addiction crisis, which worsened during the COVID-19 pandemic (SAMHSA, 2021c). In addition, SAMHSA (2021c) has issued grants in the amount of $686 million to aid in addressing Mental and substance use disorders during COVID-19. Understanding the effects of COVID-19 on biopsychosocial factors is needed to develop evidence-based interventions and policies to combat the epidemic caused by the pandemic.

Disasters and Subsequent Substance Use

The psychological effects of disasters have been long studied. These effects include depression, anxiety, PTSD, rise in suicidal ideation, and increases of substance use. Although definitions vary, most have similar components. Gulliver et al. (2014) cites a disaster as "a natural or man-made event that negatively affects life, property, livelihood, or industry, often resulting in permanent changes to human societies" (p. 125). The United Nations International Strategy for Disaster Reduction defines disaster as "a serious disruption of the functioning of a community or a society causing widespread

human, material, economic or environmental losses which exceed the ability of the affected community or society to cope using its own resources" (Makwana, 2019, p. 3090), while the World Health Organization defines disaster as a "sudden ecologic phenomenon of sufficient magnitude to require external assistance" (Makwana, 2019, p. 3090).

Disasters have a negative effect on the mental health of those impacted, including posttraumatic stress disorder (PTSD), anxiety, depression (Adams, 2006; Alexander & Ward, 2018; Makwana, 2019), prolonged grief (Moise, & Ruiz, 2016), and increased substance use (Adams, 2006: Alexander & Ward, 2018). Disaster exposure causes a variety of mental health issues (Adams, 2006) and can create stressors, disrupt daily routines, adversely affect social support networks, create financial disadvantages, bring about employment and housing instability, and circumvent adaptive coping strategies.

In addition, the National Institute on Alcohol Abuse and Alcoholism (2021) reports prior studies relating to disasters have demonstrated that people increase alcohol consumption post-disaster as a coping mechanism to contend with post-disaster stress. This may be attributable to the victim's denial of the experience or to escape from what is happening around them (Makwana, 2019). Alexander and Ward (2018) conceptualized that disaster exposure results in decreased coping self-efficacy. Coping self-efficacy, in relation to disasters, is defined as one's ability to manage their functioning and the environmental effects of the disaster (Alexander & Ward, 2018). These authors posited that the decrease in coping self-efficacy could result in an increase in substance use as a means of self-medication. Fornili (2006) reiterated this process by identifying that

perceived powerlessness after stress related disaster exposure was associated with increased alcohol use. Alexander and Ward (2018) noted that individuals with a substance use history or with pre-existing mental health issues may be more susceptible to substance use as a coping strategy.

Disasters can be categorized as either natural disasters or human-made disasters. Natural disasters occur from weather or geographical forces (Alexander & Ward, 2018) and include cyclones, earthquakes, tsunamis, floods, hurricanes, and tropical storms (Makwana, 2019). Alexander and Ward (2018) divide human-made disasters into two additional subcategories: technological and mass violence disasters. Technological disasters include incidents such as building or bridge collapses, dam failures, or nuclear reactor accidents, any event that may be caused by human error or negligence (Alexander & Ward, 2018). Mass violence disasters may include incidences of a terrorist attack or mass shootings and are at the hand of an individual or group that intends to do harm to others (Alexander & Ward, 2018).

Although it is posited that different types of disasters can have specific effects, such as human-made disasters having a higher rate of PTSD than natural disasters (Makwana, 2019), it is agreed that psychological disorders and substance use increased after exposure to both man-made and natural disasters (Moise, & Ruiz, 2016). These can include emotional instability, stress reactions, and anxiety, (Makwana, 2019) and these effects can be magnified by proximity to the disaster (Gulliver et al., 2014; Moise, & Ruiz, 2016), age of the victim at the time of exposure (Gulliver et al., 2014), length of exposure (Gulliver et al., 2014) and the duration of the effects (Moise, & Ruiz, 2016).

Human-Made Disasters

The Swissair disaster occurred on September 2, 1998, when a flight from New York to Geneva crashed off the coast of Canada, killing all 229 passengers (Grant, 1999). In a study conducted in the aftermath of the disaster, 46% of the participants (N=13) met criteria for PTSD (Gulliver et al., 2014). Prior research has identified that those who met criteria for PTSD used alcohol as a coping mechanism to forget the tragedy (Gulliver et al., 2014). In another study, volunteers who were exposed to the aftermath of the crash suffered from PTSD and increased alcohol use. However, the alcohol use increase did not occur until approximately one year after the event (Fornili, 2006).

The 2000 Holland firework disaster that killed 22 people and injured nearly 1,000, resulted when a fire spread to the factory (Gulliver et al., 2014). A study conducted two years after the incident revealed increased incidences of PTSD, specific phobias, and major depressive disorder, with persistent specific phobias and major depressive disorder continuing four years after exposure (Gulliver et al., 2014).

The 1995 Oklahoma City bombings resulted in the death of 168 individuals with hundreds more having sustained related injuries. In a phone survey conducted, over 33% of the community participants identified themselves as having known someone killed or injured in the incident. In a study conducted by Pfefferbaum et al. (2002), findings indicated an association of grief and post-traumatic stress with increased substance use behavior in disaster victims. The authors discussed the correlation of grief experiences with the increase of substance use (Pfefferbaum et al., 2002). North (1999), cited in Prevention Technology Transfer Center Network (2020), identified that 15% of direct

survivors reported increased alcohol use to cope with the psychological effects of the bombings.

After the 9/11 attacks on the World Trade Center in 2001, Manhattan residences suffered negative social and economic effects, but the long-term related psychological and substance use far outlasted the rebuilding of ground zero. This event caused loss of life, grief, interruption of social support networks, physical health related issues, housing, and economic instability. Fornili's study (2006) estimated post disaster depression and PTSD rates were twice the 1999 baseline national average. Adams et al. (2006) reported that exposure to these stressors can cause biological and cognitive alterations, resulting in physical and psychological distress. Adams et al. (2006) stated that exposure to these stressors could result in increased alcohol use as a coping strategy to avoid the circumstances and the related effects. Adams et al. (2006) found that 10% of the respondents (N=2,368) reported increased alcohol use. These researchers attributed increased alcohol use to self-medicating of psychological or physical issues and as indicated above, avoidance.

Natural Disasters

In 2005, hurricane Katrina struck the United States and caused 1,833 deaths and resulted in $108 billion in property damage (Weather.gov, 2022). Hurricane Katrina extended from August 23 to August 31 in 2005 and was considered one of the "worst natural disasters in U.S. history" (Gulliver et al., 2014, p.125). The damage extended over 90,000 square miles and affected 40 states and the Nation's capital (Fornili, 2006). A study of individuals with substance use disorders was conducted comparing individuals

before hurricane Katrina in 2004 and then post-Katrina in 2008 (Moise, & Ruiz, 2016). It was found that those exposed to the devastation of Katrina had an increased level of substance use disorders by over 35%, increasing from 7.13 per 1,000 population to 9.65 per 1,000 (Moise, & Ruiz, 2016).

The 2004 Florida hurricane lasted 7 weeks and had negative impacts on residents and public health workers alike. In a study conducted by Fullerton et al. (2013), health care workers were examined to determine the relationship of probable PTSD, probable depression, and increased alcohol or tobacco use. The study surveyed 2,249 participants using an electronic questionnaire to assess PTSD, depression, alcohol, tobacco use, increased alcohol use, tobacco use, hurricane exposure, and work demands. While 3.6% (N=51) of those participating were likely to meet criteria for probable PTSD, it should be noted that those participants not married were more likely to meet criteria for probable PTSD at 6.3% (N=45), and those who experienced loss were at 10.4% (N=36) to meet criteria for probable PTSD. In addition, those with high levels of hurricane exposure were estimated to be at 8.4% (N = 29) to have probable depression. The authors went on to determine that those with high exposure to the hurricanes were estimated at a rate of 14.9% (N = 24) for increased alcohol use (Fullerton et al., 2013). In a study conducted by Ursano (2014), cited in Prevention Technology Transfer Center Network (2020), the researchers found that communities with collective efficacy had lower rates of increased alcohol use post disaster.

In 2003, The World Health Organization identified that severe acute respiratory syndrome (SARS) is a viral respiratory disease caused by an associated coronavirus.

(World Health Organization, 2022). SARS first emerged in China and quickly spread to other countries. The result of which was President George W. Bush signed an executive order allowing the "apprehension, detention, or conditional release of individuals to prevent the introduction, transmission, or spread of suspected communicable diseases" (CDC, 2003). As was the case in our current pandemic, SARS related psychosocial stressors resulted in increased anxiety, mood, and thought disorders, adjustment disorders, and PTSD. After the SARS outbreak, Sim et al. (2010, cited in Prevention Technology Transfer Center Network, 2020) reported increases of SARS related psychiatric and posttraumatic symptoms. This study did not note any increase in substance use, but in another study (Wu et al., 2008, cited in Prevention Technology Transfer Center Network, 2020) the authors found a positive correlation of increased alcohol use three years after the required quarantine.

Summary of Disasters and Subsequent Substance Use

Exposure to stress can cause psychological distress (Keyes et al., 2012). How that stress manifests itself depends on several factors, including the type of disaster (Makwana, 2019), time of life it is experienced (Keyes et al., 2012), length of exposure (Fullerton et al., 2013) and magnitude of exposure (Alexander & Ward, 2018). Reactions to these stressors can vary, including anxiety regarding safety, functional impairment, and increased tobacco use (Pfefferbaum et al., 2002); but several studies have consistently demonstrated elevated instances of AUDs in the wake of a disaster (Adams et al., 2006; Fornili, 2006; Keyes et al., 2012). In some instances, alcohol use is a peri-traumatic response, and continued problem use is not noted (Keyes, 2012).

Summary and Conclusions

Marlatt developed an approach to address relapses and assess risks. Within Marlatt and Gordon's framework he identified and described distal and proximal risks, and tonic and phasic responses to assess issues that may lead to relapse. Substance use disorders and relapses are a biopsychosocial phenomenon (Marlatt, 1996; Jemberie et al., 2020; Larimer et al., 1999) which are multifaceted and require an integrative approach to successfully combat stressors (Jemberie et al., 2020). Largescale disasters have had a deleterious effect on mental health and a well-documented history of an increase in substance use post disaster. COVID-19 has proven that these patterns are consistent.

The effects of the pandemic will outlive the pandemic itself; individuals will likely have continued symptoms that will rise to a level to meet criteria for PTSD, anxiety, or major depressive disorder (Gordon, 2021), and will likely continue to result in an increase of substance use to contend with these issues. No other study has explored the specific stressors caused by COVID-19, through a Marlatt and Gordon's RP taxonomy: this study looks to fill that gap: not only does this study address the actual proposed phenomenon, but it also fills the gap in the qualitative methodology absent in alcohol use research. In addition to treating those exposed to COVID-19 stressors, the need to be prepared for potential future pandemics or other large-scale disasters that may have similar stressors is needed. A better understanding of the psychosocial impacts of governmental mandates and precautionary measures needs to be had to take protective measures, guide policy decisions, and allocate funding both during and in a post-pandemic period (Jemberie et al., 2020).

Shinebourne and Smith (2009) suggest that exploratory studies in substance use research is lacking. Accordingly, a qualitative design was chosen, more specifically IPA seemed to be the most well-suited methodology, as it has been described as having the goal of "getting as close as possible to the experiential content of consciousness" of the participants (Mau et al., 2019). I believe that this would be the most suitable method to explore the nuances of this proposed study. Further exploration of IPA is discussed in chapter 3.

Chapter 3 introduces the design and methodology of this study. A qualitative research approach with a phenomenological research strategy was used. One-on-one in-depth interviews to better understand the lived experiences of individuals with AUDs, that led up to relapses during COVID-19. In conclusion, this chapter presents the intended parameters of the population to be studied, ethical implications, and data collection procedures regarding the research.

Chapter 3: Research Method

Introduction

This qualitative study was conducted in response to the lack of qualitative data available pertaining to experiences and feelings that led to alcohol relapse during the COVID-19 pandemic. The purpose of this study was to explore self-identified experiences during COVID-19 of individuals diagnosed with AUDs, with the goal of obtaining a comprehensive understanding of the events, thoughts, and feelings that led to the relapse. Qualitative research allows a researcher to investigate a phenomenon to better understand the meaning an individual or group attributes to a problem (Creswell, 2011). I used a qualitative strategy to gain a better understanding of the lived experiences of participants who relapsed on alcohol during the COVID-19 pandemic. More specifically, I used an IPA approach to identify patterns without conjecture. This information may help explain some deficiencies in prevailing research regarding the stressors experienced during COVID-19 that may have contributed to alcohol relapse.

This chapter includes a detailed description of the research design, my role as the researcher, and the methodology for the study. A rationale for the use of the IPA design is outlined, as well as the justification for the sampling design and the participant pool. In this chapter, I further detail the rationale for the use of a narrative approach to data collection and the use of semi-structured interviews to fully explore topics that may arise and warrant further exploration. I explain how data analysis was conducted and the procedures used to establish the study findings. Finally, Chapter 3 concludes with a review of ethical considerations implemented to maintain data validity.

Research Design and Rationale

Within the study, I sought to answer two central research questions:

RQ1: What are the lived experiences of individuals diagnosed with AUD that led to relapse episodes during the COVID-19 pandemic, as described by them?

RQ2: What were identified stressors during the COVID-19 pandemic prior to alcohol relapse?

In addition, I explored the following sub-questions:

SQ1: What events led to the participants' relapse experience?

SQ2: Were there any shifts in participants' chronic feelings during the pandemic?

SQ3: What were participants feeling prior to their relapse?

SQ4: What meaning did the participants prescribe to their experiences?

SQ5: What factors aided participants in resistance to relapse?

The central concepts explored in this study were individuals diagnosed with AUDs, COVID-19 stressors and events, thoughts and feelings that led to alcohol relapse episodes, and what meaning the participants attribute to their relapse.

Many theories have been developed and studies conducted into what may contribute to alcohol relapse; additionally, statistics have been documented as to the increase in mental health ramifications and increased substance use that has occurred. What is not understood is the specific circumstances caused by COVID-19 that preceded and contributed to alcohol relapses. The best approach to attempt to understand these factors was a phenomenological approach, so I could explore and interpret the lived experiences of the participants.

Broad assertions and predictions about contributing factors to relapse based on prior research, such as isolation, fear, and financial concerns (Praharaj et al., 2018) are speculations that do not take into consideration the unique circumstances that COVID-19 brought to participants' lives. Through a phenomenological approach, I was able to reveal more about the phenomenon under study. More specifically, the use of IPA allowed previous study conclusions to be put aside to allow participants' narratives to evolve into identifiable data.

The goal of IPA is to make sense of a participant's social world (Smith & Osborn, 2007). In an IPA study, a researcher utilizes a phenomenological approach through the detailed examination of participants' experiences and related phenomenon. Data from various governmental agencies (CDC, 2020; CMS, 2021; SAMHSA, 2021, 2021b, 2021c) and a range of research studies (Chiappini et al., 2020; Czeisler et al., 2020; Dubey et al., 2020; Jemberie et al., 2020; Moto, 2020; Öngüret al. 2020; Simon et al., 2020; Vahratian et al., 2021) have reflected increases in substance use and relapse during COVID-19. However, no specific study had been conducted to explore the events that led up and contributed to alcohol relapses during COVID-19.

Smith and Osborn (2007) indicated that "mainstream psychology is strongly committed to quantitative and experimental methodology" (p. 54) and highlighted the need for studies that explore phenomenon deeper, rather than studies that allow for generalization. IPA is rooted in the belief that people are sense-making organisms (Shinebourne & Smith, 2009; Smith & Osborn, 2015), and through their narrative interview, a better understanding of their lived experiences can be attained without

judgment by a researcher (Lindseth & Norberg, 2004). A researcher must acknowledge the complicated connections among participants' lived experiences, feelings, and ability to convey their experiences linguistically (Smith & Osborn, 2015). These complications are what make the hermeneutic component of IPA most appropriate in the exploration of research questions like those guiding this study. The goal of a hermeneutic approach is for a researcher to develop an understanding of the phenomenology being studied (Koch, 1999). The role of hermeneutics within IPA is twofold: for the researcher to explore a participant's understanding of the experience and for the researcher to gain an understanding of how the participant makes sense of the experience (Smith & Osborn, 2007).

IPA was the most suitable approach for a study like this because the approach allows a researcher to become close to a participant's lived experience while suspending all preconceived/premature judgments. In many cases, individuals who relapse are unable to identify reasons for their uptake in alcohol use. Exploring the events leading up to the relapse utilizing a narrative approach, a researcher can enter and attempt to make sense of a participant's world without being led to a conclusion by a structured interview. In addition, a researcher can use bracketing, also known as epoché, which requires the researcher to shelve their pre-suppositions or pre-understandings about the phenomenon (Koch, 1999). In this study, prior research discussed isolation, fear, health issues, and financial concerns as contributing predecessors to relapse. I needed to suspend these prior research studies as they do not factor into the unique circumstances brought about by COVID-19. In addition, should any of these variables be a contributing factor in alcohol

relapses during COVID-19, exploration and identification of the weight the identified factor played for the participant prior to the relapse experience was explored.

Role of Researcher

In an IPA study, the participants are the experiential experts in the study (Smith & Osborn, 2007). A narrative-style interview is conducted with each participant to avoid preconceived conclusions serving to direct the data obtained. As the researcher in this study, I worked to establish rapport and provide empathy, foster trust, and avoid generating shame or judgment; this approach will produce authentic and richer data (see Smith & Osborn, 2007). As the observer in this qualitative study, I engaged with participants and asked for an account of the events that led to their alcohol relapse; the goal was to get into the participant's world to gain the insider's perspective (see Smith & Osborn, 2007).

In an IPA study, a researcher must immerse themselves in the data. This process includes reading and rereading the transcripts several times. IPA is an inductive, iterative process that requires repeated review of what the participants say to see what emerges (Smith & Osbourn, 2015). Smith and Osbourn (2007) indicated that a researcher must enter an interpretative relationship with the data, with the hope that with each reading, new insights develop, and themes begin to emerge that allow for theoretical connections. In this study, I made these connections or interpretations through the experiences and literature known to me.

At the time of this study, I worked at a nonprofit agency that serves individuals with mental health issues and co-occurring substance use disorders. In addition, my

family history includes a close family member dying due to health-related issues caused by AUD. With these experiences and the information gathered in the literature review for the study, I easily could have developed "pre-existing theoretical preconceptions" (see Smith & Osborn, 2015, p. 41) and made broad assertions or drew conclusions on why individuals may have relapsed. IPA, however, involves a technique known as bracketing to avoid a researcher's experiences and knowledge causing premature conclusions. Bracketing is the attempt of a researcher to suspend all prior judgments (Lindseth & Norberg, 2004). To avoid data collection being guided by experiences from my professional and personal life, I used bracketing to focus solely on the experiences described by the participants. Notwithstanding the need to use bracketing during the data collection process, interpretation is an integral part of the IPA approach.

Although I worked in the field that serves the population participants belong to, no participants were related to me or my employer were included. By working with participants not previously familiar to me, I hoped to maintain objectivity, avoid biases related to prior interactions or information previously obtained, and avoid any power dynamics that may affect data collection or interpretation. A more detailed account of how participants were obtained is discussed below.

Methodology

Shinebourne and Smith (2009) conducted an IPA study on addiction. In their research, they discussed the need to secure a "rich picture of the subjective-felt experience" (p. 153) of those with addictions. In their discussion, the authors stated that psychology on addiction is dominated by quantitative methods; qualitative research in

this area is useful and valuable to avoid stereotypes and myths about substance users (Shinebourne & Smith, 2009). According to Smith and Shinebourne (2012), IPA is rooted in three other theories: phenomenology, hermeneutics, and ideography. Phenomenology is focused on a participant's particular lived experiences as opposed to classification and a "predetermined category system" (Smith & Shinebourne, 2012, p. 73). Guillen (2019) described phenomenology as exploring a participant's consciousness, understanding the essence of the lived experience itself, perceiving their life through those experiences, and concluding by describing it as finding the relationship between the subjectivity and objectivity of the lived experience. Hermeneutics involves the process of interpreting (Watson, 1976). In this kind of research, experiences are verbalized, and this conveyance is not always accurate (Smith & Osbourne, 2007), so it is up to the researcher to engage, elicit, and interpret the data provided through the narratives. Idiographic studies are conducted to look at small homogeneous samples (Smith & Osbourne, 2007) to gain a rich understanding of the phenomenon. This can be contrasted with nomothetic studies in which researchers use larger sample sizes to gain generalizable results (Smith & Osbourne, 2007; Smith & Shinebourne, 2012).

Participant Selection Logic

As is the case with qualitative studies, in IPA studies, a researcher uses smaller participant pools; the breadth of the study is sacrificed for the depth of the conclusions (Smith & Osbourne, 2007). IPA studies have been done with as few as one participant and with as many as 15 (Smith & Osbourne, 2007). Although typical studies take place until no new substantive data are obtained, a term known as saturation (Palinkas et al.,

2015), Saunders et al. (2018) distinguished the parameters of saturation between deductive and inductive studies. Saunders et al. (2018) described saturation as being achieved in deductive studies when preidentified codes or themes are adequately represented. Alternatively, in inductive studies, saturation is achieved when no themes or insights are gained from data collection (Saunders et al., 2018). IPA is distinguished further than the distinctions made between qualitative and quantitative studies and inductive and deductive approaches. Data saturation is not the focus of IPA methodologies, but rather "it is intended that full and rich personal accounts are obtained from the sample size used, and concepts and commonalities are explored across the sample" (Hale et al., 2008, p. 91).

Smith and Osbourne's (2007) concerns about being overwhelmed by too much data need to be balanced with the need to satisfy saturation, and they recommended three participants for first-time researchers, cautioning that more participants may generate a vast amount of data that can become overwhelming for a new researcher. After careful consideration, I decided this study would consist of six participants in total, three men and three women to explore any gender-specific stressors. With such a small group with similar experiences, the transferability of the results would be limited. Rather, the goal of this study was to look in detail at psychological similarities and differences within the group (Smith & Shinebourne, 2012). Palinkas et al. (2015) suggested using an existing theory to identify emerging data to satisfy saturation. As indicated above, I used Marlatt and Gordon's RP model as my theoretical framework.

Participants were identified through purposive sampling, which limited participation to individuals who identify as having an AUD. To accomplish a homogeneous pool, I sought to recruit participants in social media chatrooms that cater to individuals with AUDs, such as self-help chatrooms. Solicitations included a description of the study and offered a link to the screening questionnaire. Participant screening consisted of questions such as the following: Have you ever sought help to control your drinking? During COVID-19 were you attempting to maintain abstinence? Did you relapse during COVID-19? These questions were designed to secure participants who would offer data that are "information-rich" and related to the phenomenon of interest. (see Palinkas et al., 2015, p. 2). Based on affirmative responses to these inquiries, potential participants were included in the participant pool. Solicitations also included preferred methods of contact (i.e., phone or email) for planning Zoom interview.

Researcher Developed Instruments

As indicated above, narrative interviews were conducted to elicit data from the participants. Notwithstanding, the prompts and starter inquiries listed in Appendix "C" were utilized to gain information without tainting the answers with researcher biases. Utilizing this approach required confirmation that the data collected, and the subsequent findings agreed, a term known as content validity (Creswell, 2007). Creswell (2007) identifies some validation strategies to be developing trust with the participants, peer review or debriefing of the researcher, identifying, and clarifying researcher presuppositions or biases, member checking, and thick, rich collection of data: these approaches are further discussed below.

In developing an interview protocol for an IPA study, the comfort of the participants was of the utmost importance (Drinkwater et al., 2013; Smith et al., 2009). Securing accurate, reliable data from the participant was unlikely if the participant did not trust the researcher (Smith et al., 2009). As indicated above, the use of a narrative interview was used for data collection; notwithstanding the use of prompt questions were used to initiate the interviews and to explore certain aspects of the lived experiences. When rapport with the participant is attained, it is essential that the participant and researcher have a "common understanding of what the questions mean and how the answers are to be understood/interpreted" (Drinkwater et al., 2013, p. 283). Questions listed in Appendix "C" below were based on similar questions asked by Marlatt (1996) in his study on high-risk behaviors and by Mau (2018) when studying Alcohol relapse and near-relapse experiences: their questions were modified to address the inquiry and circumstances of this study. These questions are structured as open-ended inquiries to collect data rich accounts of the experiences (Drinkwater et al., 2013).

Debriefing is described as external checks on the research process. It allows a third party to play "devil's advocate" (Creswell, 2007, p. 208) and to keep the researcher honest. This process was employed during data collection and analysis and was documented. To address researcher presuppositions and potential biases reflexivity, reflection, and journaling were used. Vicray et al., (2017) describe the use of reflexivity, reflection, and journaling to achieve quality and validity in data collection. Reflexivity refers to the researcher's ability to self-monitor biases, beliefs, and personal experiences in relation to data collection and analysis. This is a particularly salient aspect in relation

to IPA as the need to utilize bracketing is more than just setting aside biases, but rather requires the researcher to acknowledge them and to be aware of their potential influences (Vicray et al., 2017). Reflection allows for the comparison of the researcher's biases in relation to the data collected and journaling of reflection will allow for deeper levels of reflection and increased insight into thoughts and feelings from the process of journaling (Vicray et al., 2017).

Member checking refers to the researcher taking their "data, analysis, interpretations back to the to the participants so they can judge accuracy and credibility" (Creswell, 2007, p. 208). Creswell (2007) recommends not offering raw data, but rather providing description of themes to solicit agreement or identify deficiencies. When presenting analysis, client verbatim statements were added to demonstrate themes; this approach will also serve to allow readers to understand how themes were identified and developed.

Procedures for Recruitment, Participation, and Data Collection

To gather participants, I posted digital flyers on social media platforms for individuals in recovery from AUD. Platforms will include ones such as Facebook pages, Craigslist, LinkedIn, and chatrooms for self-help in AA. In addition, physical flyers were posted at community centers and counseling agencies that offer support for individuals with substance use disorders, such as Long Island Thrive and Family Service League. Posts and flyers described the study with a link directing potential participants to the screening questions listed above and a form requesting contact and demographic information. Based on responses, participants were called via their preferred mode of

communication (i.e., phone, email) and arrangements were made for video conferences where I conducted a brief interview to verify answers and to confirm appropriateness for the narrative interview, which were then scheduled for a later date. This procedure took place until six participants (three male and 3 female) were secured. Although Smith and Osbourne (2007) recommend three participants for student researchers, I am proposing three male participants and three female participants, to have the recommended number of participants for each gender. Should any identified participant fail to complete the interviews, the procedures were replicated to secure any additional needed participants. All communication after the initial screening was made through email and phone, where permitted. If recruitment results in a low number of participants, the same procedures described above were repeated to an expanded number of social media platforms.

After the initial screening protocol, a narrative interview was conducted via Zoom online conferencing. All interviews were recorded using Zoom's record feature when available or utilizing a digital recorder when not. Thereafter recordings were transcribed for analysis. As indicated above, data was collected through a narrative interview, all data was collected from this researcher solely, the guide for which can be found in Appendix C. Initial questions were posed broadly to initiate the participant in sharing their story. Mau et al. (2019) conducted an IPA study on addiction and their opening questions were framed as "Can you describe the day the relapse/near-relapse took place?" and "Did you do anything specific on that day?" Comparable questions were utilized to commence the data collection process. At times, I utilized questions such as "What did that mean to you?" or "Can you tell me more about that?" When the participant was sharing their

story, these questions were used to elicit additional information without altering the trajectory of the participant's narrative. Based on this researcher's current professional experience, it was anticipated that each narrative interview will take between 60-90 minutes to explore relapse experiences during COVID-19. Due to the nature of relapse experiences and the emotions involved, no interview episodes were allowed to go over 90 minutes. If additional time was needed to gather data from individual participants, a second interview was scheduled. Alcohol relapse is at times fraught with shame and embarrassment. Upon completion of the narrative interview, I spent additional time with participants to debrief and to address any questions that the participants may have.

Participants often struggle to verbalize what they are feeling, thinking, and have experienced (Smith & Osborn, 2007). Accordingly, notes were taken during the narrative, and upon completion of the participant's narrative, follow-up questions were asked to draw out factors if the researcher senses "that maybe the participants themselves are less aware of" or to probe areas of interest that may arise (Smith & Osborn, 2007). Smith and Osbourne (2007) call this technique of asking broad questions initially and moving to more specific questions, funneling; this technique will allow for a more accurate sense of the participant's world. To avoid unintentionally directing the narrative between interviews, these follow up questions were modified for each participant, depending on the direction in which the participant's narrative goes. After data analysis, members participated in a member checking process in which this researcher provided description of themes and verbatim statements to demonstrate how themes were identified. The goal

of this step was to ensure validity by having participants confirm the accuracy and credibility of the findings (Creswell, 2007).

Data Analysis Plan

Data was obtained through narrative interviews, Smith and Osbourn's (2007) suggest that it is ideal to get participants to speak about the topic with "as little prompting as possible" (p. 61). It is recommended that questions be subtle and less direct to get participants to open up about their experiences (Smith & Osbourn, 2007) and that questions should be used as prompts, should the participant need to focus on the experience, or to serve as a "reminder to the interviewer to address certain domains" (p.61): these prompts are listed in Appendix "C" and all elicit narrative responses that address the research questions of:

RQ1. What are the lived experiences of individuals diagnosed with AUD that led to relapse episodes during the COVID-19 pandemic, as described by them?

RQ2. What were identified stressors during the COVID-19 pandemic prior to alcohol relapse?

Data analysis was conducted utilizing Smith and Osbourn's (2007) six-step approach to IPA data analysis, as exemplified in their study of chronic benign back pain (1998). The first step is a reading of the initial interview several times for the researcher to immerse himself in the data. Smith and Osbourn (2007) describe this process as a necessary component so that the participant is the sole "focus of the analysis and to gain an impression of the text as a whole" (Mau et al., 2019, p. 290). Items of potential significance should be noted: content, language, and context, should be noted with

interpretative comments (Smith & Shinebourne, 2012). The next stage is explorative in nature (Mau et al., 2019) and requires the researcher to make notes of emerging themes (Smith & Shinebourne, 2012); notes can consist of descriptions, impressions, and reflections, which are conceptual in nature (Smith & Shinebourne, 2012). Mau et al. (2019) define an emergent theme as "a statement of what was important in a section of the interview" (p. 290). Emergent themes are then grouped together into superordinate themes (Mau et al., 2019) with conceptual similarities (Smith & Shinebourne, 2012).

This process was then repeated for all other narrative interviews. The challenge was to enter each subsequent analysis process without preconceived impressions from the prior analysis; Mau (2019) states that each subsequent analysis is treated as unique. Smith and Shinebourne (2012) identify this challenge and acknowledge that each prior analysis becomes part of the hermeneutic process and influences future analyses. Mau et al. (2019) describe the final stage as including a main list of all themes and matching them to participants' verbatim statements; as indicated above, this process also allows future readers to verify reliability (Osbourn & Smith, 1998). Smith and Shinebourne (2012) state success can be evaluated if a future reader can "track the analytic journey from the raw data" through to the theme list (p. 78). In addition to superordinate themes, discrepant data will also be categorized and reviewed to evaluate any initially unseen emerging themes. No coding software was used for analysis of this data.

Issues of Trustworthiness

Credibility

Credibility, also known as internal validity, refers to the truth of the data; this can include the data as provided by the participants and the interpretation of the data by the researcher (Cope, 2014). Osbourn and Smith (1998) discussed approaches to ensure internal validity and reliability of an IPA research study. The authors suggested the use of internal coherence and presentation of evidence as approaches to satisfy related concerns. Osbourn and Smith (1998) described internal coherence as a process in which the researcher concentrates on whether the conclusions of the study are internally consistent and justified by the data. This was a concern in that the interpretation by the researcher can be biased by his own experiences. As mentioned above, these experiences were meant to be suspended through the process of bracketing. But the reality of the situation is that bracketing may not always be conducted as intended. To aid in verification that the researcher was not biased in any way, Osbourn and Smith (1998) suggested the inclusion of verbatim evidence from the transcriptions of the participants' narratives be included in the study discussion so that the reader can verify the researcher's interpretation. Both procedures were employed in the current study. Not only were theme charts tied to participant raw data, but confirmability was addressed by the inclusion of interview transcripts with the research results (Pepper & Wildy, 2009). These approaches were utilized to ensure that the research results will remain credible.

Transferability

In conducting the literature review, one of the gaps that were addressed by this proposal was psychology's inclination to experimental studies (Smith & Osborn, 2007). Accordingly, a qualitative approach was chosen for this study, so the exploration of a deeper understanding of the phenomenon could be obtained. The narrative interview approach offered by IPA was specifically chosen to avoid influences by the researchers. This approach also provided a deeper, richer description of the participant's lived experience, without impact from the researcher that may be otherwise encountered using a structured interview. Due to the use of purposeful sampling to solicit a small homogeneous sample (i.e., limiting a variation in participant selection), I recognize that the that the results would not be transferable to all populations; but generalizability within this select population was attained through the data collection that offered a deeper, thicker understanding of what the participants thought and felt prior to alcohol use.

Dependability

To address dependability, Osbourn and Smith (1998) describe the use of matching themes to participant's verbatim statements; this process also allows future readers to verify reliability. This step allows the future reader "track the analytic journey from the raw data" themselves (Smith & Shinebourne, 2012, p. 78). Journaling was also utilized to avoid my biases and preconceived notions (Vicray et al., 2017) from affecting data. The use of the journals further supports dependability and will serve as audit trails for researcher thought processes.

Confirmability

Confirmability refers to the data representing the actual participants' responses, and not to data after it has been influenced by the researcher's biases (Cope, 2014). To allow the phenomenon to unfold naturally and reveal itself, bracketing was employed during the data gathering portion of the study. To aid in this effort, I conducted narrative interviews where the participants were asked to describe the events leading up to the relapse episode. This avoided the use of a structured interview, which can unintentionally draw conclusions. The process is described as having two stages (Smith & Osborn, 2007) or a "double hermeneutic" (Smith & Shinebourne, 2012, p. 53). During the narrative interview the participants were trying to make sense of their world: then after the interview was concluded and transcribed, the researcher read, reread, and attempted to identify themes to make sense of the participants trying to make sense of their world. When collecting data, the researcher bracketed all prior known research to allow the current phenomenon to unfold and speak for itself (Smith, & Shinebourne, 2012). To further aid in avoiding researcher bias reflexivity, reflection, and journaling were used. The combination of the three allowed the researcher to monitor biases and preconceived conclusions, reflect upon them while increasing insight during the journaling process (Vicray et al., 2017). These approaches were utilized to maintain confirmability.

Ethical Considerations

Approval of Walden University's Institutional Review Board (IRB) was gained for the proposed study. Informed consent and confidentiality requirements of the IRB were adhered to in conducting all research for this study.

All participants were recruited by posting information of the study on social media pages that offer support or congregation of individuals with AUDs. By approaching recruitment in this way ethical concerns regarding privacy and pressure were alleviated. Prior to participation, details regarding the study, its parameters, and the rights of the participants were posted and/or reviewed.

Informed consent forms were submitted to Walden IRB for approval before any participant contact was made; the proposed informed consent form can be found in Appendix B. Informed consent included the nature of the study, how data collection was conducted, the use of recording of the interviews, limited use of the data collected, all aspects of confidentiality, the voluntary nature of participation with no compensation, the right of the participant to withdraw, that this study was not intended to benefit the participant directly and should not have been construed as therapy. After a presentation of the study and all ethical considerations, participants were given ample opportunity to ask any questions they may have had concerning the study. Participants were required to acknowledge informed consent forms, through email, prior to interviews.

To encourage truthfulness, confidentiality was discussed beyond informed consent. The client's right to privacy was introduced and how the same related to the interview, the recordings, the transcripts, and the research results were explored. Participants were advised that all data were coded, and no identifying information was kept with transcripts or recordings, to maintain anonymity. In addition to client names not being on any transcripts or data, client contact information was only retained for as long as necessary to complete the study. Participants were advised that data collected were

shared with research committee members only. Participants were advised that participation is voluntary and if at any time they wish to withdraw from participation, they could do so, and none of their data would be utilized and all records would be destroyed.

All interviews were conducted via Zoom or similar video conferencing software. Any such interview required a unique login invitation link to ensure that only this researcher and the intended participant were in attendance. I stored all data on a portable hard drive that was password protected. When accessing the data, I used my personal computer, which was housed in my home and was equipped with an auto-lock feature which prevented access if the computer is unattended. I was the only individual with access to both passcodes. In addition to digital data, any notes, paper transcripts, or similar documentation was stored in a locked file cabinet in my home. Once again, no identifying participant information was on any documents. At the completion of the study, all data was put on recordable DVDs, all paper copies would be shredded using a crosscut shredder, and all digital data storage devices were erased and reformatted. Thereafter, in accordance with the Walden University Student handbook, IRB section relating to Student responsibilities, the DVDs were retained in a confidential, secure manner for 5 years from the date of the chief academic officer's approval of this dissertation (Walden University, 2021). These confidentiality and security protocols were reviewed with each participant prior to any interviews and client concerns were addressed before initiating narrative interviews.

Participants were advised of my capacity as a PhD candidate and a New York State credentialed Substance Use Counselor. Since substance use relapse is an emotionally charged issue, participants were encouraged to debrief and were given ample opportunity after the interview was completed to do so. If additional support was needed, participants were provided with contact information for SAMHSA disaster distress helpline (1-800-662-HELP (4357) where they could secure free, confidential, and anonymous, counseling through a toll-free number.

Summary

The research questions I proposed sought to secure an essence of participants' cognitive, emotional, and physical, understanding of their experiences. IPA can provide a rich understanding of these experiences and provide a voice to these experiences which may otherwise be unheard of or misunderstood (Shinebourne & Smith, 2009). IPA is best suited when one is concerned with complex or novel situations (Smith & Osbourne, 2007). Here the novelty and complexity involved the stressors encountered through the COVID-19 pandemic. Based on prior research, many causes for relapse have been identified. For purposes of this study, Marlatt and Gordon's RP taxonomy (Larimer et al., 1999) was used as the framework to maintain focused and evidenced-based conclusions. In addition, relapse is not a linear process (Witkiewitz et al., 2011). The factors of tonic and phasic processes, high-risk situations, cognitive processes, and individual coping behaviors, make relapse complex or emotionally laden and dynamic, which makes IPA the most suitable approach to this study. The purpose of this study was to gain a level of depth that quantitative studies do not gain; it was not meant to develop generalizable

results. The ideographic nature of an IPA study is focused on gaining a full understanding of a small set of case studies (Smith & Osbourne, 2007).

Within an IPA design, the role of the researcher is a key component to a successful study. The researcher must establish a rapport and a safe environment to encourage the production of authentic, rich unencumbered data. Thereafter the researcher must immerse himself in the data while suspending all preconceived notions as to causes of the phenomenon. It is then that the researcher attempts to make sense of narratives describing participants' experiences.

Because this study was limited to individuals with AUD, who relapsed during COVID-19, participants were solicited through online chat rooms established to support individuals with substance use disorders. Participants were screened through an online questionnaire based on self-reported information to determine eligibility. Thereafter, initially eligible participants participated in a short interview to confirm eligibility, gather additional demographic info, and schedule the actual interview for data collection. This study utilized six participants (three males and three females) and data collection was obtained through narrative interviews.

Data analysis was conducted utilizing Smith and Osbourn's (2007) six-step approach. The steps include interviewing the participants, followed by reading transcripts several times to immerse oneself into the data. The next stage required identifying items of significance, such as terms, language, and context. Thereafter the researcher identified emerging themes. Finally, themes were then grouped together into superordinate themes

with conceptual similarities. This process was then continued for each subsequent participant.

Issuers of trustworthiness were addressed as follows: credibility was secured through the use of internal coherence and presentation of evidence. Transferability was addressed by obtaining a deep, rich account of the participant's experiences. Dependability was accomplished by matching verbatim participant statements to themes and through journaling. Lastly, confirmability was addressed using reflexivity, reflection, and journaling.

This study may be of use to healthcare practitioners in offering care with greater understanding as the COVID-19 pandemic results continue through the near future. The results gained from this study may also prospectively help develop interventions to be utilized to avoid similar increases in mental health and substance use issues, should another pandemic occur. In addition, the data can be utilized to guide policy and funding decisions in a similar event.

In Chapter 4, I present the results of the study, using the data gathered from the narratives, after all information was transcribed. Common themes that emerged were identified as they relate to the above-referenced research questions. Chapter 4 will include verbatim portions of transcripts so readers can verify the researcher's interpretation; this approach was meant to ensure validity.

Chapter 4: Results

Introduction

The purpose of this phenomenological investigation into alcohol use during the COVID pandemic was to explore the lived experience from the perspective of those who relapsed during the pandemic and to identify stressors that led to the relapse. The focus of this study was on identifying themes of experiences or stressors that led to the relapse, while using Marlatt and Gordon's RP taxonomy (Larimer et al., 1999) as the theoretical framework for the theme identification. Exploring the data collected allowed for a perspective to emerge that is unique to the participants, the experiential experts, to develop a foundation to address the research questions:

RQ1: What were the lived experiences of individuals diagnosed with AUD that led to relapse episodes during the COVID-19 pandemic, as described by them?

RQ2: What were identified stressors during the COVID-19 pandemic prior to alcohol relapse?

This chapter addresses the study's setting, demographics, data collection methods, data analysis, evidence of trustworthiness, and results, concluding with a summary.

Setting

Interviews were expected to take place virtually through Zoom video conference software; however, due to participant technological issues, two interviewees participated through the audio-only portion of the Zoom session. Although in-person interviews may have yielded richer data, the use of face-to-face interviews would have further limited the participant pool. In addition to video conference interviews, participants were advised at

the initial recruitment and at the interview that individual theme identification would be emailed to the participants once data analyses were conducted as part of the member-checking process. Such emails were sent to all participants once the theme analysis was complete.

All members were solicited from various social media sites, community centers, and counseling sites, excluding my place of employment. All participants were solicited through flyers; I made no direct solicitations. Although paper flyers were distributed at the sites, all participating interviewees were obtained through social media recruitment. None of the participants were known to me prior to the research. Due to concerns of the interview causing triggers for shame and embarrassment, each interview ended with a debriefing to explore any risks or discomforts that may have been caused during the data collection process. None of the participants expressed any reactions that would cause a concern or a need to explore the use of the SAMHSA national helpline for those facing mental and substance use issues or other referral.

Demographics

Six participants were recruited to participate in this phenomenological study. Three were male and three were female. The ages of participants ranged from 33 to 62; male participants were 33, 38, and 62, and female participants were 38, 40, and 42. All the participants resided in the United States. No other demographic information was collected.

My initial attempts to post solicitations to Facebook groups were not well received. Many groups (approximately 20 out of 26) rejected the requests, stating, “The

purpose of the group was support for those in need and not data mining." Upon receiving IRB approval, I submitted the participant solicitation to the remaining six Facebook groups and within 4 hours I received 89 requests to participate, and four hours after that, the number grew to 138 requests. At that time, I deleted all the Facebook postings as I had reached sufficient potential participants. Informed consent forms were sent to all 138 potential participants. I received 37 responses, and scheduled interviews with all of them; 18 of the 37 did not show up or respond to follow-up emails. Of the remaining 19 scheduled interviews, four of the participants were two different people attempting to participate a second time; 14 others either did not meet participation criteria or presented in an untrustworthy manner, and the interviews were terminated. Only one successful interview was conducted through Facebook solicitations.

My impression was that all these participants were attempting to participate to receive the incentive gift card. Further, it seemed that my solicitation was passed through an email chain where recipients attempted to capitalize on these opportunities. In reviewing similarities between those who attempted to participate, the following were noted: all had Gmail email addresses that were similarly structured (e.g., smithmichael@gmail.com), all had issues connecting through Zoom, all shut their cameras off prior to or immediately after logging in. My settings on the Zoom invitation required participants to have their camera on, so this was being actively bypassed or shut off intentionally. Most participants claimed to be diagnosed by their physician and all had what seemed to be a similar accent.

To obtain the remaining needed participants, I placed solicitations on Craigslist. Modification was made to avoid passive solicitations. In Facebook, postings go to everyone in the group automatically, or passively, through their feeds, whereas Craigslist requires an interested party to click to see the posting. Although I was able to secure my remaining participants from Craigslist, my postings were removed toward the end of my data collection process. Attempts were made to obtain an explanation as to why the postings were removed, but no reply was received from Craigslist administrators. I requested help from the Member Help Chat room, and other members reported that a solicitation in multiple geographical locations violated Craigslist terms of use, other members stated that repeated use of the same advertisement violated the agreement not to mechanically reproduce postings, and yet another member reported that any postings that discuss COVID-19 are automatically flagged for removal.

Data Collection

Six participants (n = 6) took part in virtual interviews. Two unexpected events occurred during the data collection, the first of which related to participant solicitation, and 18 responses being deemed disingenuous. I discussed the matter with the IRB and the committee, and those individuals were invited not to participate; this was an unanticipated result of offering the participation incentive. The second unexpected event was that interviews were shorter than projected. All interviews lasted approximately 45–60 minutes, as opposed to the estimated 60-90 minutes discussed in Chapter 3. Otherwise, the data collection plan was preserved.

Each interview was recorded, and after each interview, the recordings were transcribed. All transcription was accomplished through the Microsoft Word transcription feature. All interviews took place in December 2022; four took place through Zoom video conferencing and two took place through Zoom with audio only due to participant technological issues. Prior to each interview, participants were screened to verify they met participation qualifications and were thereafter emailed the informed consent. Participants were asked to reply acknowledging their agreement to the terms of participation by replying "I consent." To maintain anonymity, copies of all consent acknowledgments were saved separately on my hard drive. Once the informed consent form acknowledgment was received, participants were contacted to schedule an interview at a mutually convenient time.

Each interview was initiated by addressing any questions related to the informed consent form and securing confirmation they agreed to the interviews being recorded. Once approval was obtained, the interview began in accordance with the approved interview guide (see Appendix B). Interviews were structured as a narrative process so that questions did not lead to the data gathered. As participants provided certain facts, follow-up questions were presented to explore and secure additional information about the data provided. This process allowed participants to explore their lived experiences without my influence over the focus of the interview. Prior to the interviews, participants were assigned a random number between 100 and 9999 through Google's random number generator; this number allowed participants to be identified for tracking purposes

without disclosing any personal information. After each interview, Microsoft Word was used to transcribe each recording and then each transcription was proofread for accuracy.

Data Analysis

Data analysis followed Smith and Osbourn's (2007) six-step approach to IPA data analysis. As laid out in Chapter 3, the approach to data analysis began with a reading of the initial interview to immerse myself in the data. During this process, items of potential significance were noted in the margins of the transcription. In stage two, I reread the transcripts and notes and attempted to conceptualize emerging themes. At this stage, I conducted member checking in an interpretive manner. I sent emails to each individual participant with the identified themes and supporting statements through which the theme was conceptualized. Common themes identified included isolation, loneliness, deviation from a normal routine, lack of social support, self-medicating, and escapism. In the next stage, I grouped emergent themes together into superordinate themes that had similarities.

I repeated this process for all other narrative interviews. Mau (2019) cautioned that researchers should not look at subsequent transcripts through the lens of the prior analyzed transcript. While this did not seem to be a challenge, what did seem to occur reflected the literature review findings during analysis and interviews. I attempted to avoid jumping to conclusions based on knowledge from the literature and allowed the participants' stories and emerging themes to unfold naturally; debriefing and journaling aided in this process. The final stage of the process required that I develop a main list of all themes and match them to participants' verbatim statements. This allows future readers to "track the analytic journey from the raw data" through to the theme list (see

Smith & Shinebourne, 2012, p. 78). No coding software was used for data analysis. Based on the information provided, there were no discrepant data; all participant-identified contributing factors were categorized into subthemes and then grouped into superordinate themes.

Evidence of Trustworthiness

Credibility

The issue of credibility was a concern at the beginning of this study with an initial group of recruits seeming fraudulently responsive to secure a gift card for their involvement. When this issue became a concern, I communicated with IRB and my committee members and discussed the approach to disqualify individuals that did not seem credible. To confirm validity of participants, screening questions were confirmed at the beginning of the interviews. Once qualifying data was determined, initial interview questions allowed for further confirmation of authentic participants; for example, some participants asked for explanation of "what abstinence meant." In these situations, participants who had questionable authenticity were thanked for their interest in the study and advised that they did not meet the study's criteria. Although, I did not want to eliminate legitimate participants who wished to take part but ensuring the credibility of the data was the primary focus. As indicated above, 18 out of 19 requests to participate were denied due to suspect credibility.

Credibility, internal validity, was also addressed with the use of internal coherence during the data analysis (Osbourn & Smith, 1998). Internal coherence requires that the researcher ensures that the conclusions of the study are justified by the data and

not biased by their own experiences. As indicated in chapter three, I am a substance abuse counselor, and as such I worked with numerous clients through the COVID pandemic. It is my opinion that these experiences did not affect data analysis, though the research conducted for the chapter two literature review was repeatedly recalled during data analysis. However, I utilized debriefings and journaling to avoid drawing predetermined conclusions.

As another effort to ensure credibility, member checking was utilized. Emails were sent out to all the participants once subordinate theme analysis was complete. The emails included subordinate themes with supporting verbatim statements made from their interview. Of the six emails sent to each individual participant, only two of the participants (participants 882 and 7417) replied confirming the identified themes. Reminder emails were sent to the remaining participants two weeks afterwards, which yielded the remaining response all of which reported agreeing with the theme identification. In addition, the use of participant verbatim statements were used in the results portion below, so that reader confirmability of theme identification can be tracked to the raw data.

Transferability

As addressed in chapter three, this study will have limited transferability due to the explorative nature of the study and the homogenous participant pool of the study. This study was designed to address a gap in the literature, namely that research involving addiction should be less quantitative and more exploratory (Smith & Osbourne, 2007). Notwithstanding the limited transferability, the results of this study will provide a deep,

rich understanding of this phenomenon that will have generalizability within this population.

Dependability

Dependability is addressed by utilizing verbatim statements during the analysis process; in the results portion below precise quotes from the interviews were utilized and aligned with corresponding themes. Utilizing this approach will allow findings to be verified by future readers, allowing them to "track the analytic journey from the raw data" themselves (Smith & Shinebourne, 2012, p. 78). In addition, I utilized reflective journaling to avoid biases and drawing any conclusions unsupported by the collected data.

Confirmability

To secure confirmability, bracketing was used to avoid confirmation biases based on preconceived notions. At the inception of the data collection process, I was concerned about my experiences of counseling patients during COVID for substance use disorders and relapses they suffered serving as a component that could undermine confirmability. This component was manageable in terms of bracketing. What served as more of a challenge was awareness of the research gathered during the literature review. I found myself reflecting on the research as the interviews were being conducted. In this respect, additional effort needed to be placed on bracketing. I focused on asking follow-up questions only pertaining to the data presented by the participants, so that their lived experiences could unfold naturally and without being guided by the questions themselves.

In addition, after each interview, I reflected upon the interview to confirm no biases influenced the data collection.

Regarding the interviews themselves, 60 to 90-minute narrative interviews were intended at the proposal stage, but during data collection interview lengths ranged from 40-60 minutes. At the proposal stage, it was anticipated that the participants would tell their story with occasional pointed questions regarding salient events. What occurred were brief recaps of the events with many follow-up questions throughout the discussion to elicit additional details about the participant-described events. This challenge should have been anticipated, based on work experience, and understanding that this population is often not exceptionally communicative. Lastly, after interviews and data analysis took place, interpretative debriefings were utilized with a licensed psychologist, where verbatim statements were presented with theme identification to confirm that the themes were supported by the participant interviews.

Results

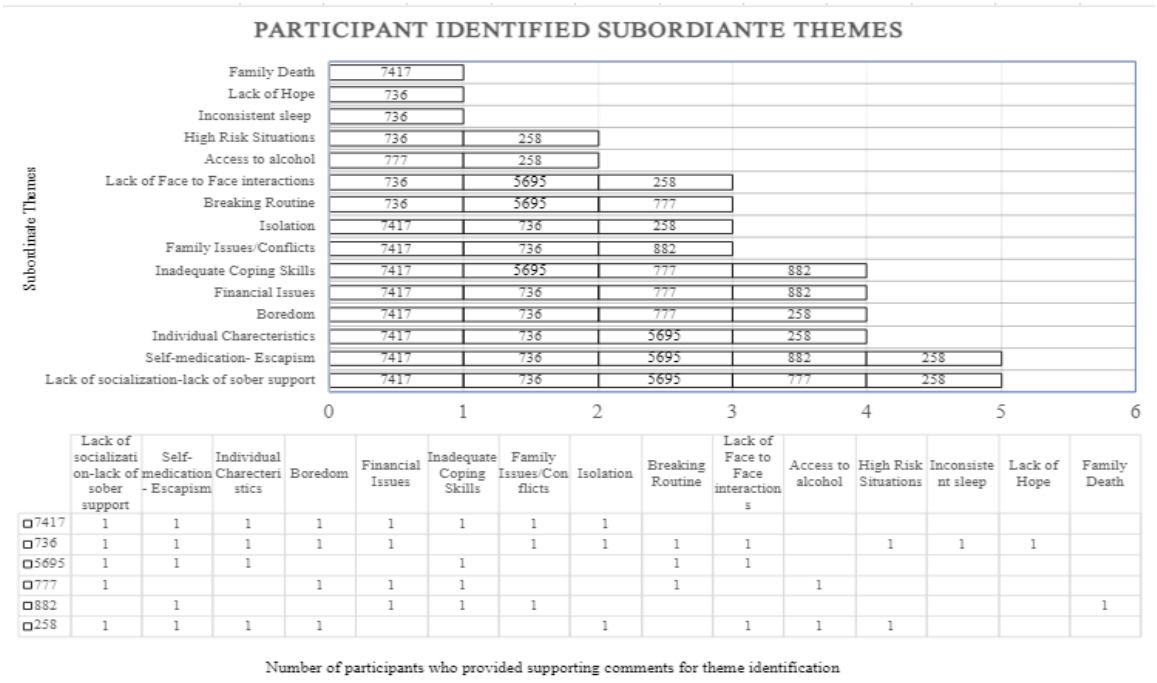
The focus of this study was on the most significant events that contributed to alcohol relapse during the COVID-19 pandemic. Each of the participants was able to identify contributing factors or events that led to their relapses. For example, Participant 777 was clear that the "loneliness and seclusion" were the main reason for her relapse, while Participant 7417 was certain that her "living situation, my in-laws moved in with us" coupled with increased disagreements with her husband about the situation was significant. Across the board, all the participants understood what issues played a role in

their relapse. I identified their ability to readily discuss these events as they have previously examined the identified events.

Six themes seemed significant, as they were prevalent in more than 50% of the narratives, while four themes were only prevalent in 50% of the narratives. Five other identified events were discrepant and were only relevant to either one or two of the participating interviews. These included ease of access to alcohol, high risk situations, lack of hope, inconsistent sleep, and family death. Figure 5 identifies the categorization of the statements to the identified subthemes (see also Appendix D). The discrepant events were noted as significant factors in the individual's relapse, but these items were distinguished from other stressors that were mentioned and prevalent among more than one participant.

Figure 5

Participant-Identified Subordinate Themes



After identifying subordinate themes, these were logically grouped into superordinate themes utilizing Marlatt's RP taxonomy to create the categories. Table 1 below demonstrates the subordinate themes that were categorized into superordinate themes. These themes were identified as phasic responses, tonic processes/proximal risks, and intrapersonal factors. Phasic responses were made up of identified subordinate themes of self-medication, escapism, inadequate coping skills, lack of sober support, lack of socialization and isolation, lack of face-to-face contact, disruption in normal routine, boredom, family death, inconsistent sleep, and lack of hope. Tonic processes and proximal risks were made up of identified subordinate themes of access to alcohol, financial issues, exposure to high-risk situations, and family issues and conflicts. Intrapersonal themes were made up of identified subordinate themes that consisted mainly of personal views of one's self, characteristics, and existential views. Based on the volume of the statements made and data collected, each of the subthemes and supporting statements cannot be explored individually. Rather only the themes with the largest prevalence were explored, with all other statements being summarized in Appendix D.

Table 1

Categorization of Subordinate Themes Into Superordinate Themes

Categorization of Subordinate Themes into Superordinate themes	
Phasic Responses	Self-medication- Escapism
	Inadequate Coping Skills
	Lack of socialization-lack of sober support
	Isolation
	Lack of Face-to-Face interactions
	Breaking Routine
	Boredom
	Family Death
	Inconsistent sleep
	Lack of Hope
Tonic- Proximal Risks	Access to alcohol
	Financial Issues
	High Risk Situations
	Family Issues/Conflicts
Intrapersonal	Individual Characteristics

Superordinate Theme 1: Phasic Responses

The most common theme found among participants who relapsed during the COVID pandemic was phasic responses. Phasic factors are cognitive and affective responses (Grace, 2000; Hendershot et al., 2011) and are transient. These included subordinate themes of self-medicating, escapism, inadequate coping skills, lack of sober support, lack of socialization, isolation, lack of face-to-face contact, disruption in normal routine, boredom, family death, inconsistent sleep, and lack of hope. For phasic responses, the most significant subthemes were self-medicating, escapism, isolation, lack of sober support and lack of face-to-face contact. These are discussed below. The factors listed above and not discussed below were not highlighted as major contributing factors

by the participants, or were only identified by a few participants, which were interpreted as them not being noteworthy: these included inadequate coping skills, breaking of normal routine, boredom, family death, inconsistent sleep and lack of hope.

Self-Medicating and Escapism

Within the self-medicating and escapism subtheme, supporting statements included these made Participant 7417 made in the following quote:

> I was feeling very overwhelmed and anxious and not knowing how to deal with what was going on around me- So I just was at home. I had nowhere really to go to share my feelings with or talk to and there was just a way to kind of shove feelings aside, I guess for a little while.

The participant stated that prior to the relapse she felt "alone and somewhat desperate and depressed" and was feeling "like I really had nobody. Like I was just left to deal with it." When asked what she identified as why she thought she relapsed in a broader sense, the participant stated:

> To deal with the situation I was in, and it was just something that brought me a little bit to a better kind of feeling. So, like I had a lot of guilt around it too. Like wanting to kind of leave the situation, but not being able to like leave kids in the situation type of thing so there was a lot of guilt and so some of that was also wanting to drink to kind of not to think about it.

Overall, the participant stated that the relapse resulted in a feeling "of being stuck in the situation, not having a way out…not being able to leave … nothing being open or having a place to go."

Participant 258 reported having pre-existing issues with anxiety, depression, PTSD related to traumas of childhood abuse, homeless, domestic disputes, and being incarcerated. When asked if he thought that the anxiety and depression contributed to his relapse, the participant responded "Yeah, it makes me feel more comfortable, man when I'm out and about and around other people and, uh, it's like a like a like a tranquilizer." Participant 5695 reported being stressed by pandemic factors as a contributing factor for relapse and stated "The pandemic that was kind of like a weird time. Like you're there's a lot of like things going on that you were not like sure of… just like it was like having to wear a mask and everything that was going on I guess."

Participant 736 reported significant circumstances that were interpreted as self-medicating and escapism, making statements such as "I also didn't want to recognize it [drinking] or put the effort into stopping it because I didn't know like that, I was the only one that had to change and nobody, and nothing else was changing." When asked to expand upon this comment, the participant said, "to have a lot of times something to look forward to, or for other things to change, not just like to get hope to hope and a lot of times there." The participant stated that the isolation impacted her emotional state and made her feel "like numb to it, somewhat lazy and depressed." The participant reported history of emotion driven drinking and stated that the same pattern continued through the pandemic.

Similarly, Participant 882 made comments such as he would drink when he was "in distress or when the whole world is turning around against you, you want to check out some alcohol." But when he drank, he "tried to forget about his pains." The participant

said he believed he relapsed immediately after the lockdown and reported he drank from depression.

Isolation, Lack of Sober Support, and Lack of Face-to-Face Contact

The statements made pertaining to isolation, lack of sober support, and lack of face-to-face contact were equally as significant as self-medicating; with five of the six participants stating that these factors played a role in their relapse. Lack of sober support is identified as a distal risk by Marlatt (Witkiewitz, 2011), but I have chosen to classify it within phasic responses, as the circumstances described by the participants were lack of support due to the circumstances surrounding the lack of support. When Marlatt discussed lack of support, it seemed to be an inherent issue with the individual. The circumstances described by these participants were that the lack of support was caused by the lockdown, thereby making the issue more of a response to a transient set of circumstances. In discussing socialization with Participant 736 she stated that items that led to her relapse were who she was socializing with, working from home, boredom, and extra time on her hands. During exploration of each of these items, the participant elaborated that the social component was both quantity of friends and quality of friends. Participant 736 stated "the friends I had pre-pandemic made better choices and weren't really going out, so I became closer to the friends that were more available." She further elaborated "like the friends that were available for me to hang out with, they didn't have as much like family responsibility and so they were around much more than those that were worried about getting sick from COVID and wouldn't socialize." The participant continued to say that the lack of socialization impacted her emotional state and made her

feel “like numb to it, somewhat lazy, and depressed.” When asked, the participant reported that had she had friends that made better choices available it would have counteracted the negative influences of the people she was spending time together with. The participant stated that since the lockdown has waned, her quantity and quality of friends have increased and since then she has been able to maintain abstinence for longer periods of time. She reports now having more options so she does not spend time together with people who drink a lot or does not bring as much money as she would have; both of which support her sobriety.

Participant 5695 similarly identified the lack of interaction as a contributing factor to their relapse. The participant stated that “being stuck in the house alone” during the pandemic caused him to increase use to more than he was drinking before the abstinence period. The participant stated that had he not been in the lockdown he would have been working or spending more time with family and that would have occupied his time. Upon exploration of these comments, he indicated that when at home it gave him more free time, and if he weren’t in the lockdown he would have been at work and “interacting with people as opposed to sitting on the couch by himself.” The participant stated that he was not in a relationship during the pandemic, but had he been in one “It could have helped because … if you kind of go off track that they can kind of like maybe kind of like guide you back on the track or if they realize like maybe you’re heading the wrong way.”

Participant 258 stated that the biggest contributing factor to his relapse was “I was in the house, I was bored, I didn’t want anyone around me, I didn’t want people in my

house" and "the only thing I could do was go to the corner store to get beer." When asked to elaborate, participant 258 stated:

> There was no place to [go] I didn't have…be honest with you I had nowhere to go. I didn't have nowhere to; I didn't have nobody that was that was trying to be sober. Man, you know around me. Access to anybody man … I live in a section of Queens … we don't have no groups. You don't have no meetings, you don't have, you know you got to travel a distance. Now man, you know it's not, It's not, it's not, It's not sober friendly.

When asked if there were any other contributing factors to his relapse, the participant said, "I don't think so; I couldn't go nowhere so all I could do was sit here and drink."

Participant 7417 also expressed isolation and lack of socialization as significant in her relapse episode, stating "I just was at home. I had nowhere really to go to share my feelings with or talk to and there was just a way to kind of shove feelings aside, I guess for a little while." The participant stated that she did not feel like she could discuss stressors with her husband and that often he did not want to deal household stressors, so he would just leave the home leaving her to contend with her needs. The participant stated that she did not feel like she could talk to other household or family members about her stressors and her desire to relapse, as they were the reason she wanted to drink. The participant stated that prior to the relapse she felt "alone and somewhat desperate, depressed and just feeling like I really had nobody. Like I was just left to deal with it." The participant stated that had she not been in the lockdown, she could "go for a run or go exercise. A lot of things were closed then, so I could not really do that at all. I would

probably do those things, or even just go to a friend's house or go or just go to work." When asked what meanings she prescribed to not having people to talk to or others to share her emotions with she reported "being lonely and being misunderstood." Upon exploration she stated that if not in lockdown she could have connected with "friends who knew her better and could have kept busy, so she could have come back and dealt with the situation better." When asked if self-help were open, would she have gone? She indicated that she would have attended to gain support from others who understood what she was going through. Overall, the participant stated that the relapse resulted in a feeling "of being stuck in the situation, not having a way out…not being able to leave…nothing being open…having a place to go."

Participant 777 began the interview by describing the pandemic as "it was loneliness and seclusion and probably like everyone else…I'd just say isolation kind of got the best of me." Upon exploration the participant reported she felt:

> Like I had no one or no one wanted to…you know, you know, talk, and felt like I had no one to talk to. No one to obviously hang around with when everyone was social distancing and everything was closed and working from home, it was just very lonely.

Participant 777 reported that she has some family that lives about an hour away from where she resides, so socializing with them was infrequent. The participant stated that her roommate had a boyfriend during the pandemic, so although she was able to fill some of the void relating to the participant's loneliness, the roommate had been staying with her boyfriend a lot of the times. The participant was asked prior to the pandemic, if

she thought a relapse was going to occur, what would she did to avoid drinking, she stated:

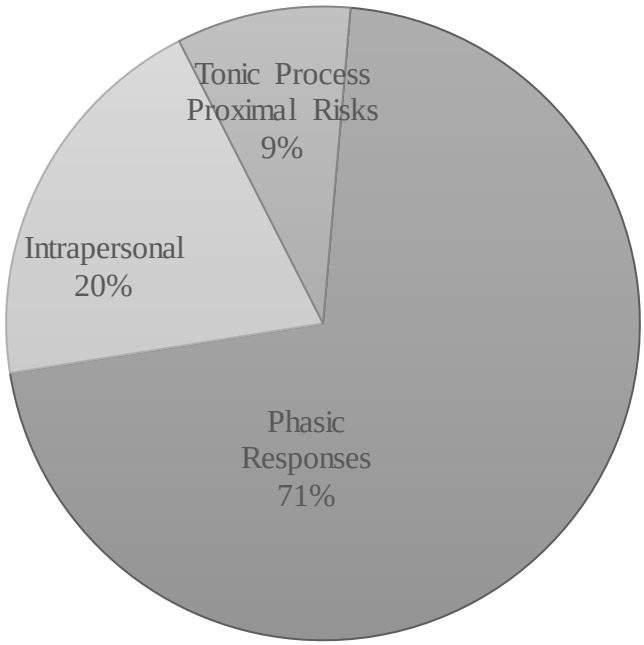
> I mean I just had like friends or even siblings to call and either like they would just talk me through or stay on the phone with me or we would be able to go for a walk or go to a movie or something and just kind of get the change of pace but. You know it wasn't and there was more I could do on my own, like just go out and about and do some of those things as at the same time you know, even myself and it just kept me busy.

The participant stated that she worked during the pandemic, but interactions with co-workers were strictly professional, so did not offer any support to avoid relapse.

When discussing isolation, participants 5695 and 777 revealed a specific factor relating to the need for face-to-face interactions. Upon exploration of these comments, participant 5695 indicated that when at home it gave him more free time and if he weren't in the lockdown he would have been at the facility and interacting with people as opposed to sitting on the couch by himself. I inquired to determine if the down time or the lack of interaction was the issue, the participant stated that "I think the lack of it [face-to-face interactions] because like being around people and just talking to other people face to face helps a lot of times and if you're facing kind of like problems and just being able to talk to other people helps out sometimes." This issue was also distinguished by Participant 777 when she stated she used her phone to aid in relapse avoidance, but then added "I think it just was I would feel like bothersome or a nuisance and didn't always want to make the call or something you know just it was a lot more."

Figure 6

Prevalence of Superordinate Themes Based on Individual Subordinate Themes



Superordinate Theme 2: Tonic Processes and Proximal Risks

The second most prevalent superordinate theme among the participants was tonic processes and proximal risks: tonic processes are described as "chronic vulnerability to relapse" (Mau et al., 2019, p. 286) and are stable factors in one's life, while proximal risks are a subcategory of tonic processes and are situational in nature and represent an immediate risk of relapse. Within the superordinate themes were the following subordinate themes: access to alcohol or exposure to high-risk situations, financial issues, and family issues or conflicts.

Access to Alcohol and Exposure to High-Risk Situations

Access to alcohol was grouped together with high-risk situations; these themes were prevalent in 50% of the participants. Participant 777 reported that she did not keep alcohol in her home, but her roommate had alcohol in the apartment. The participant reported that during the pandemic her roommate spent a lot of time with her boyfriend, so the participant used the roommate's alcohol for the relapse. The ease of access to alcohol also played a role in Participant 258 's relapse: he reported that the Bodega is "50 feet from his home", in addition there were "two others on my block and one around the corner" and that "they didn't close anything." When asked how the accessibility to the alcohol played a role in his relapse, the participant responded stating "to be in the house of boredom and in my own mind, my own device, I mean, listen I told him I got some roommates that they're going. They'll go get it anytime. It's feasible to get it back, and it's a party……we start our day with about 7 or 8 [drinks] and we go on."

The ready availability of the alcohol was grouped together with high-risk situations. Participant 736 reported that her husband smoked marijuana and during the pandemic his use increased, which caused her alcohol use to increase. Similarly, Participant 258 reported that he lives in his home with other people (roommates), and he would drink when they would.

Financial Issues

Financial issues were a topic that was discussed among three of the six participants. Participant 822 reported being depressed due to his father's death and "other physical challenges": which he later described as financial challenges during the

pandemic. The participant stated that he and his wife are entrepreneurs, and their business ventures were negatively impacted by the pandemic. The participant said that being the head of the family and financial concerns was attributable to more than 50% of his depression. The participant also said when he was drinking, he lost some cash (it was stolen) and that the loss of the monies further exacerbated his depression, which caused him to drink.

Participant 7417 also reported financial concerns and stated, "I lost my job so." When asked what meaning she prescribed to the events that led to the relapse she reported "not being busy and not having her own finances." I asked her to expand upon what was meant by "not having her own finances", she explained "not being in control and not having choices due to having to rely on her husband for money." She continued to state, "the jobs I have don't allow me to collect unemployment." Similarly, Participant 736 stated that financial concerns typically exist in her life, but they were a bit more prevalent during the pandemic and they did contribute to her wanting to drink, and then then added "it kind of made me forget about it a little bit, but it didn't take care of the problem of having money."

Family Issues and Conflicts

Family conflicts were identified as a trigger among 33% of the participants. Participant 7417 reported that during the pandemic she had to take her husband's parents to live with her family. She proceeded to state that the burden of caring for them fell on her, that she did not feel like she could discuss stressors with her husband and that often he did not want to deal with his parent's needs, so he would just leave the home leaving

her to contend with her stress on her own. Participant 7417 stated that her husband would say he had to leave with work, but that she did not believe he was doing so, but rather believed he was going out to leave the situation. The participant reports that there was an increase in disputes between her and her husband during the lockdown, elaborating that "a lot of things were said that really couldn't be taken back" also adding that her husband was "mean…….and about how I'm dealing with things and how you know he was mad about how I talked about his parents" and how she gained weight or did not take care of herself. She reported early in the pandemic when she and her husband would fight, they would do it in private but towards the end it was happening in front of the parents and the kids "he, just like didn't care like he wasn't really hiding things like his like true colors came out."

The participant reported "I feel like I saw the worse part of my family, about my husband more than anything else." Similarly, Participant 736 reports that there was an increase in family disputes during the lockdown. Participant 736 reports that she separated from her husband right after the pandemic and reported that they were not planning to get separated, but things got worse during the pandemic.

Superordinate Theme 3: Intrapersonal Themes

The last superordinate theme was intrapersonal factors, which were made up of themes surrounding personal views of one's self, characteristics, and existential views. Two of the six participants reported a family history of alcoholism as a prevalent factor of relapse; both reported that the family history was paternal.

Two of the other participants made statements regarding their perceived view of their relationship with alcohol. Participant 258 began the interview stating, “I am a drunk, I drink to get drunk”, he later stated in “my mind it is OK to drink, I don’t need a crowd around me to tell me I need to drink.” The participant stated that he had previously attended detox and rehabilitation programs, but that it was only to get rest, never to get sober. When asked to expand upon this he said he would attend “to let his body heal before starting to drink again.” Towards the end of the interview, the participant summarized I am not so bad off…all his life challenges and said that “right now I guess I’m thankful for that…if I had a beer right now, I’d toast to it.” Although not as extensive, Participant 5695 stated that prior to the relapse he thought he could handle a few beers, but that is not the way it ends up. When explored further Participant 5695 explained:

> In my mind I’m always thinking like one or two is not going to hurt and then I have one and two and it always turns out to be 10 or pretty much. I keep on going until I black out. So, like for me there’s never just one or two, it just never happens that way. That’s not the way I think, it always leads to a blackout.

These comments were noted and interpreted as that the relapse was inevitable in the face of significant stressors.

Alternatively, Participant 882 stated that he realized he had a problem with Alcohol when it began to adversely affect his career and his business (approximately age 25-30). The participant’s interview exemplified his feelings of self-worth as a man to his success as a businessman. The participant reports that leading up to the relapse he was

very depressed and “it has a way of getting to a man”, the participant said that being the head of the family and depression related to financial concerns was attributable to more than 50% of his depression.

Summary

This study set out to explore two questions: what were the lived experiences of individuals diagnosed with AUD led to relapse episodes during the COVID-19 pandemic and What were identified stressors prior to alcohol relapse? The results of this study identified 15 different participant identified stressors and three main superordinate categories of identified stressors that led to relapse: these were interpreted as phasic responses, tonic processes and proximal risks, and intrapersonal factors. Phasic responses represented 79% of the identified causes to the participants’ relapses; while tonic processes and proximal risks represented 9% and Intrapersonal characteristics represented 20%. In Chapter 5, I discuss these findings in relation to the literature review. Chapter 5 includes the introduction, interpretation of the findings, limitations of the study, recommendations, and implications, culminating with the conclusion.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In this qualitative study, I explored the lived experiences of individuals who identified as having an AUD and who relapsed during the COVID-19 pandemic. My goal was to identify themes of preceding events that contributed to participants' relapse episode. Qualitative research into the lived experiences of relapse during COVID-19 is sparse, and qualitative research into relapse in general is limited (Shinebourne & Smith, 2009). Because of this gap in the literature, I chose IPA to explore participants' experiences. Participants were asked to describe the events leading up to their relapse experiences and joined in exploration of the meaning ascribed to the relapse itself. This study's purpose was to determine the most prevalent self-identified themes that triggered participants' relapses during the pandemic.

In relevant literature on the topic of alcohol relapse, scholars have identified several contributing factors to relapse, such as emotional dysregulation (Clarke et al., 2020; Mau et al., 2019; Ottonello et al., 2019) or repeated stressful life events (Praharaj et al., 2018), and other studies have been focused on self-medication as a cause for relapse (Chauhan et al., 2018). The COVID-19 pandemic brought about a unique set of stressors that did not allow analysis of relapse triggers from the existing literature. All the factors discussed were present during the pandemic but identifying which was most prevalent had not been explored. Based on this gap, these deficiencies were best addressed by exploring the unique perspectives of the experiential experts.

The results show that one theme was much more predominant than all the others. Phasic responses represented 79% of the identified causes of participants' relapses with phasic factors and cognitive and affective responses to transient stressors. Phasic responses were made by all participants, with the most common relating to self-medication and isolation. The theme of tonic processes and proximal risks represented 9% of identified causes of relapse. Tonic processes are an individual's chronic vulnerability, while proximal risks represent an immediate risk of relapse. The most significant of these related to financial concerns, followed by family conflicts. The last identified theme was intrapersonal characteristics, which made up 20% of the explored subordinate themes; these included personal views of oneself, characteristics, and existential views. All participants were open to exploring their relapse episodes, and each could identify the contributing events easily. Each participant had put forethought into the reason for their relapses.

Interpretation of the Findings

The most common theme identified from the study as causing relapse was phasic responses to COVID-19 related stressors. Marlatt (1996) identified several contributing factors to relapse, which included high risk situations, interpersonal pressures, direct social pressures, tonic processes, and phasic responses. Although Marlatt did not weigh these factors by prevalence, this study confirmed that phasic responses are a contributing factor to relapses and identified they were the leading cause for relapse among the participants. Despite the prevalence of phasic responses, the other identified themes, tonic processes, and intrapersonal characteristics, were also predominant among the

participants. These factors were also identified in Marlatt's RP taxonomy. Based on other research, it is well known that disasters have resulted in increased substance use (Alexander & Ward, 2018; Gulliver et al., 2014; Makwana, 2019; Moise & Ruiz, 2016). In the COVID-19 pandemic, similar outcomes and research on the pandemic demonstrated increased substance use. (Chiappini et al., 2020; Czeisler et al., 2020; Dubey et al., 2020; Jemberie et al., 2020).

Theme 1: Phasic Responses

The significance of these findings is that in the face of this natural disaster, increased alcohol use was caused by phasic responses, made up of the following subordinate themes: (a) desire to self-medicate or escape current situations, (b) isolation, (c) lack of sober support, (d) lack of face-to-face contact, (e) breaking normal routine, (f) boredom, (g) lack of hope, (h) inconsistent sleep, and (i) death of a family member. Research of each subordinate theme has been identified as playing a role in alcohol abuse.

Self-medication and escapism describe the use of substances to "alleviate specific symptoms of psychosis and to gain relief from negative affect and stress" (Pettersen et al., 2013, p. 2). The self-medication hypothesis has been a popular model in substance use research and is described as the motivation for individual substance use to avoid experiences of dysphoria, such as distress, depression, anxiety, restlessness, or unhappiness. In the current study, although only 83% of the participants identified self-medicating or escapism as their cause of relapse, all the participants described feeling this aspect of dysphoria. This theme has been demonstrated in other studies, particularly with

the use of alcohol post-disaster (Adams et al., 2006; Larimer, 1999; Makwana, 2019). Fornili (2006) identified alcohol use as a method to contend with realizations of perceived powerlessness.

Isolation and lack of sober support were a byproduct of the pandemic. With mandatory lockdowns and remote school and work becoming the new normal, residents of the United States and abroad had limited contact with others. More specifically, although Zoom meetings and web-based meetings became more common, this was not an adequate replacement for face-to face contact. Mau et al. (2019), Chiappini et al. (2020), Dubey (2020), Gunnell (2020), and Moto (2020) all found that isolation caused by COVID-19 was detrimental to mental health and SUD. This theme is also prevalent in other disaster research (Adams, 2006; Fornili, 2006). What is not clear is if the disruption in interactions caused mental health issues that compelled individuals to self-medicate or if the isolation prevented sober support. Marlatt's theory identifies self-medication as a phasic response, but also offers lack of social support as a distal risk. There seems to be no single answer, and the assessment is individually specific. In the current study, Participant 5695 clearly identified lack of sober support as a contributing factor to his relapse when he stated "If you kind of go off track that they can kind of like maybe kind of like guide you back on the track or if they realize like maybe you're heading the wrong way." Whereas Participant 7417 attributed her relapse in part to having to "deal with the situation I was in, and it was just something that brought me a little bit to a better kind of feeling…and so some of that was also wanting to drink to kind of not to think about it."

Breaks in routine have been found as a theme in COVID-19 research (American Psychological Association, 2021; Czeisler et al., 2020) as well as other disaster research (Adams, 2006). In discussing these circumstances, participants identified the break in routine as a contributing factor to other themes. Participant 5695 and 777 reported that the deviation from going to work regularly undermined interactions at work that had aided in sober support. Conversely, Participant 258 stated that the break in routine resulted in boredom, also adding being in the "house of boredom and in my own mind, my own device"—which I interpreted as a component of self-medicating or escapism.

Lack of hope has been identified as a contributing factor to increased substance use. Theodoropoulou (2020) referenced a book entitled *The Pastoral Clinic: Addiction and Dispossession Along the Rio Grande* by Angela Garcia, in which hopelessness in the Rio Grande is attributable to increased heroin use. Additionally, Theodoropoulou (2020) indicated that in Greece, relapse is also associated with a collective sense of hopelessness, deriving from an over-10-year-long financial and social crisis (p. 6). The COVID-19 pandemic was an uncertain time. Initially there was no indication that a vaccine was in sight, and governmental agencies were not able to predict how long the lockdown would last. For example, in New York state, Governor Cuomo provided expansive daily reports on the status of the pandemic, and these media reports highlighted the increase of the country percentages of COVID-19 diagnosis, which contributed to feelings of hopelessness. These media reports further enhanced the feelings of hopelessness and increased daily patterns of screen time (Dubey et al., 2020). These aspects are directly pertinent to Reyes-Huerta et al.'s research (2018), in which they

identified sobriety success rates were higher and discounting rates were less impactful when fixed periods of time were the focus of sobriety. Therefore, in the pandemic situation, with no end in sight, these factors of hopelessness and the open-ended nature of the pandemic could have led to increased levels of relapse.

Regarding inconsistent sleep and death of a family member, both subordinate themes were minorly reported. Participant 736 was the only member who described inconsistent sleep as a factor in relapse, stating she "was a little depressed but so I wanted the day to go faster so that I wouldn't really be awake when I didn't need to be like when I was done with work…have dinner and go to bed instead of being awake," which resulted in her being awake during normal sleep hours. Clearly this was a factor of escapism, but she identified the inability to sleep at night as a contributing factor to her relapse. Kadam et al. (2017) previously identified sleep problems as a contributing factor to alcohol and opioid relapse. The researchers reported that 30% of those who participated recognized that sleep issues were a factor in their increased alcohol use (Kadam et al., 2017). Pettersen et al. (2013) and Ottonello et al. (2019) identified these same results.

Death of a family member has been identified as a contributing factor to alcohol relapse (Praharaj et al., 2018). The death toll during the COVID-19 pandemic was at staggering levels, with total deaths reaching more than 4.5 million worldwide (SAMHSA, 2021; WHO, 2021). Although these two factors were sparsely reported by participants in this study, they contribute to the most prevalent identified superordinate theme of phasic responses.

Theme 2: Tonic Processes and Proximal Risks

The second most prevalent superordinate theme was tonic processes and proximal risks. Within this superordinate theme were the following subordinate themes: access to alcohol or exposure to high-risk situations, financial issues, and family issues or conflicts. Access to alcohol was identified by two participants. Participant 258 reported living up the block from bodegas and liquor stores whose business hours were not impeded by the pandemic. This statement was a clear result of many jurisdictions not restricting liquor store hours. During the lockdown, governmental authorities deemed alcohol to be an "essential commodity" (Dubey et al., 2020, p.818) with the NYS Liquor Store Association (2020) justifying the decision stating that the decision will "assist the public in getting through these challenging times". Participant 777 reported that her roommate had alcohol in the house, the ease of access to which facilitated her relapse. Marlatt (Larimer et al., 1999) describes incidents such as these as apparently irrelevant decisions (AIDs), stating that the relapse process begins before the use of alcohol. In this case the allowance of the liquor to remain in the apartment determined that the relapse would occur at some time thereafter. Marlatt describes these decisions are not "overtly recognized" (Larimer et al., 1999, p. 154). As such, the liquor in the apartment for Participant 777 was not the cause of the relapse, but the result of a predetermined decision.

High risk situations were yet another subordinate theme within the superordinate theme of tonic processes and proximal risks. Participant 258 reported that he lived in his home with other people (roommates), and he would drink when they would drink.

Similarly, Participant 736 reported that her husband smoked marijuana and during the pandemic his use increased, which caused her alcohol use to increase. Marlatt and Gordon's theory suggests that exposure to a high-risk situation may prompt a potential relapse, but the individual's response is what will determine if the relapse occurs or not. (Larimer et al., 1999).

Family conflict has been found to be a contributing risk factor to relapse episodes. (Praharaj et al., 2018). Dubey et al. (2020) identified this as being a significant factor in increased substance use during the pandemic. In the current study, Participants 736, 882, and 7417, identified family conflict as a preceding event to their relapses. Most notably Participant 7417 reported that there was an increase in disputes between her and her husband during the lockdown. Early in the pandemic they would engage these in private but as more time went by, he would do this in front of everyone. The participant reported "I feel like I saw the worse part of my family, about my husband more than anything else." Indistinguishably, Participant 736 reported that she and her husband suffered an increase in disagreements during the pandemic and that they were currently separated, even though prior to the lockdown there was no thought of doing this. In Praharaj et al.'s (2018) study on alcohol relapses, marital conflict was found to represent 27% of the identified factors contributing to relapse. Dubey et al. (2020) also found that family disharmony was a significant factor in the rise of COVID related relapses during the lockdown.

Theme 3: Intrapersonal Characteristics

The last superordinate theme was related to intrapersonal characteristics. Intrapersonal themes were identified subordinate themes that consisted of personal views of oneself, one's characteristics, and existential views. Sureshkumar et al. (2017) identified that family history was an identified contributing factor to relapses in his study. In each of these identified stressors, Marlatt's concept of abstinence violation effect (Larimer et al., 1999; Marlatt, 1996; Witkiewitz & Marlatt, 2004) should be taken into consideration.

Abstinence violation effect is described as an emotional response and can result in the individual attributing the use of alcohol to a personal failure, which in turn results in subsequent uses of alcohol (Ludgate, 2021). Similarly, these intrapersonal characteristics may serve the same purpose as abstinence violation effect, meaning that one's view of self may create the perspective that relapse is unavoidable. This was the pattern with Participants 7417, 736, 777 and 258. Participant 777 reported a history of relapse when "hanging around a bad crowd of friends" so when this pattern began during the lockdown, relapse seemed inevitable. Whereas Participant 258 stated "I am a drunk, I drink to get drunk." and "My mind it is OK to drink, I don't need a crowd round around me to tell me I need to drink." Participants 7417 and 736 both reported a family history of alcoholism. In these situations where participants feel that relapse is inevitable, the relapse episode did not occur at the time that the drink is taken, but rather the relapse began at the time that the individual believed that the drinking was inevitable. This is in

line with Marlatt's theory showing connections between interpersonal characteristics lending to confirmation bias and relapse (Larimer et al., 1999).

Limitations of the Study

Four limitations of this study were the small homogeneous and self-selected sample (n=6), concerns regarding researcher bias, participant recollection of the phenomenon, and the initial challenges faced in securing participants. This qualitative study utilized six volunteer participants to explore their lived experiences. Furthermore, the study focused on individuals who identified as having an AUD and who relapsed during the pandemic lockdown. The utilization of only six participants with these unique characteristics limits the transferability to other populations. These limitations were known and discussed in the preceding chapters; notwithstanding these limitations, in developing this study I decided that transferability was not the goal. Rather, the procurement of a deep, rich understanding of the lived experiences of the participant's phenomenon was the desired result.

As indicated in chapter 1, I am a substance use counselor in Suffolk County New York and worked in this capacity during the COVID lockdown. This was a concern initially, as I thought that my experiences as a counselor might bring a bias and taint the data collection or analysis process. Osbourn and Smith (1998) discussed the use of bracketing to set aside preconceived conclusions. It was found that prior experiences were easily controlled through reflective journaling and debriefings. What was more of a challenge was setting aside information gained from the literature review through the interviews, and this also was addressed through reflective journaling and debriefings.

In addition, the original design of the study was for interviews to be narrative and that was adhered to, but in some cases the participants were not very forthcoming with details and provided very curt renditions of what occurred. To gain the information needed, many follow-up questions needed to be asked. I remained mindful of this as an issue and limited follow up questions to obtain details only pertaining to the data the participants provided. In addition, all themes were tied into verbatim participant statements so that all interpretations could be confirmed by future readers.

The other concern regarding limitations for this type of study is the participant's recollection of the explored incident. This study took place in December of 2022, and most participants reported that the relapse episode occurred between July and November of 2020. After two years' time passed, there was a concern of the accuracy of the recalled experiences. Notwithstanding, as indicated in Chapter 4, most participants were able to identify their causes for relapse quickly, which I interpreted as their having previously reflected on their experiences.

The last limitation that should be discussed was the initial challenge relating to participant solicitation. As indicated, initial solicitations resulted in 37 scheduled interviews, 18 did not show up and of the remaining 19, 18 were deemed not be genuine and were dismissed. Institutional Review Board approval had allowed for a $15 gift card to be provided to those who participated. It was my interpretation that the promise of a gift card motivated individuals who did not meet criteria to attempt to participate. When this issue was identified, participants were scrutinized during the initial stages of their participation for authenticity.

Recommendations

Recommendations for further research are based on the strengths and the identified limitations of this study. Future studies should be conducted without incentives, with the goal being to secure participants who are not solely driven by the inducement. Although adequate screening took place, the selection process was fraught with individuals who attempted to participate for the wrong reasons.

The exploration of this phenomenon has identified the most prevalent themes. Expanding on these findings could be increased by quantitative studies that further identify events preceding one's relapse. This approach could result in data that would be transferable to larger populations.

Another area for study is how initial relapses may have played a role in continued alcohol use or prevented resecuring abstinence. This approach should be conducted through a lens of Marlatt's abstinence violation effect. Such research could explore if perception of oneself after relapse is a significant factor in continued alcohol use. This could be especially important in understanding transitions from lapse to relapse. Resulting data could be used in the development of treatment approaches to remediate individuals who have had a "slip" (Ludgate, 2021) and facilitate avoiding continued use.

Lastly, additional explorative research should be conducted with individuals who suffer from substance use disorders. Shinebourne and Smith (2009) stated additional qualitative research with this population is needed to "demystify drug and alcohol use and replace stereotypes and myths about addiction with more accurate information that reflects the reality of substance users" (p. 153). These recommendations will aid in

understanding the unique perspectives of this population and will help develop treatment approaches for the general population as well as to help handle increased substance use in the event of another disaster or pandemic.

Implications

There are many implications from this study, but the most significant is that it addresses the lack of explorative data available for individuals with substance use disorders, as well as the lived experiences endured during the pandemic lockdown. The era of the Corona virus lockdown is not far behind us and with new variants being identified, future pandemics are a true possibility. The use of current data cannot be applied to these circumstances, and future research should be conducted and applied to developing refined treatment approaches, and guide governmental mandates, statutes, and allocation of resources. Prior research has identified causes for relapse but understanding the specific triggers in a pandemic state is an essential goal for future researchers.

In working with the participants, interviews revealed that phasic responses, tonic processes and proximal risks and intrapersonal characteristics were the most prevalent superordinate themes. A review of these findings through member checking confirmed that participants agreed with the data analysis. This process assisted participants in increasing insight into their maladaptive behaviors, which may help in avoiding future relapses.

Understanding how the stressors related to a large-scale disaster or the need to isolate will affect individuals with AUDs could help in circumventing national increases in substance use to contend with the circumstances. The information gained from this

study and future research has the potential to help individuals, the profession of psychology and guide policy decisions. Positive social change may be accomplished through developing individual interventions to address these triggers to relapse, offering continued support and interactions in the event of another pandemic or lockdown and providing data that can support legislation that may dictate governmental spending in the face of another large-scale disaster. The application of this data may increase positive social change by developing strategies to aid in trigger avoidance that has led to relapse. This approach can lead to aiding this marginalized population and allow for a more efficient allocation of resources, to avoid increased substance use and related mental health issues that have created a strain on individual and national health care budgets.

Conclusion

This interpretative phenomenological analysis explored the lived experiences of individuals with AUDs that relapsed during the pandemic lockdown. Literature on alcohol use relapse has several studies that have identified causes of relapse. Most of the literature is quantitative in nature. In addition, very few studies have explored the lived experiences of relapse during the lockdown. This study addressed these gaps.

The results of this study clearly indicate that phasic responses were the most prevalent identified cause for relapses during the pandemic. Results further showed intrapersonal characteristics, tonic processes, and proximal risks, were also factors. I believe that the data procured by this study can aid in avoiding increases in alcohol use should we encounter another pandemic or large-scale disaster. In addition, it is my hope that this study leads to additional qualitative studies that further explore this topic and

subsequent quantitative studies to aid in developing transferable results to a larger population. The procurement of this data and development of treatment approaches can help support this population and undermine feelings of marginalization and being misunderstood.

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Appendix A: Solicitation Posting

Research Participants Needed

Causes of Alcohol Relapse During COVID

 Are you 18 or older?

 Do you Live in the United States

 Do you have an Alcohol Use Disorder?

 Did you relapse during COVID-19 Pandemic?

If you answer yes to all these questions,

you are eligible to participate in this online research study.

The purpose of this study is to evaluate components that may have led to

Alcohol Relapse during the Pandemic.

Participants will not receive any monetary compensation.

For more information, including informed consent,

please email Robert Ibraham at r----------m@gmail.com

Appendix B: Informed Consent

You are invited to take part in a research study about alcohol relapse during COVID pandemic. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study seeks Six (6) volunteers, three (3) male and three (3) female, who:

- Are over the age of 18, and
- live in the United States, and
- identify as having an alcohol use disorder, and
- desired to maintain abstinence, and
- Relapsed during COVID-19 pandemic.

This study is being conducted by a researcher named Robert Michael Ibraham, who is a Doctoral Student at Walden University.

Study Purpose:

The purpose of this study is to explore and identify themes that preceded or triggered alcohol relapse episodes.

Procedures:

This study will involve you completing the following steps:

- take part in a confidential, audio recorded narrative interview (phone option available) (60-90 minutes)
- review a summary of identified themes (this is called member checking and it takes 20-30 minutes, phone option available)

Here are some sample questions:

- Going into the pandemic, were you trying to maintain abstinence? (Prompts: How long had you been abstinent? What support did you utilize to maintain abstinence?)
- Did there come a time during the pandemic that you relapsed? (Prompts: What events led up to the relapse? Were there any stressors that happened immediately before the relapse occurred? Was anyone with you at the time of the relapse? Can you describe the emotions that were happening at that time? Why do you think you drank at that time?)
- What meaning did you prescribe to the events that led up to the relapse?
- Were you tempted to drink prior to the relapse event?
- What prevented you from drinking prior to the relapse event?
- How do you feel about your relapse experience?
- What meaning did you prescribe to the relapse event itself?

Voluntary Nature of the Study:

Research should only be done with those who freely volunteer. So everyone involved will respect your decision to join or not.

If you decide to join the study now, you can still change your mind later. You may stop at any time. Please note that not all volunteers were contacted to take part.

Risks and Benefits of Being in the Study:

Being in this study could involve some risk of the minor discomforts that can be encountered in daily life such as sharing sensitive information. With the protections in place, this study would pose minimal risk to your wellbeing. If any portion of the

discussion causes emotional concerns, participants can call the SAMHSA National Helpline at 1-800-662-HELP (4357). This service is open 24/7, 365 days a year, is free and confidential, and offers treatment and referral information for individuals and families facing mental and/or substance use disorders.

This study offers no direct benefits to individual volunteers. The aim of this study is to benefit society by identifying events that may precede an alcohol relapse during a future pandemic or other large-scale disaster. Once the analysis is complete, the researcher will share the overall results by emailing you a summary.

Payment:

No compensation is available for this study.

Privacy:

The researcher is required to protect your privacy. Your identity will be kept confidential, within the limits of the law. Be aware that the researcher's professional role as a Credentialed Alcohol and Substance Abuse Counselor requires him to report any possible instances of child abuse or neglect to the authorities. The researcher is only allowed to share your identity or contact info as needed with Walden University supervisors (who are also required to protect your privacy) or with authorities if court-ordered (very rare). The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. If the researcher were to share this dataset with another researcher in the future, the dataset would contain no identifiers so this would not involve another round of obtaining

informed consent. Your confidential information will be safeguarded on a portable hard drive that will be password protected. Data were accessed through the researcher's personal computer, which is housed in his home and is equipped with an auto lock feature which will prevent access if the computer is unattended. This researcher will be the only individual with access to both passcodes. In addition to digital data, any notes, paper transcripts or similar documentation were stored in a locked file cabinet in the researcher's home. Once again, no identifying participant information will be on any documents. At the completion of the study, all data were put on recordable DVDs, all paper copies will be shredded, using a crosscut shredder, and all digital data storage devices were erased and reformatted. Data were kept for a period of at least 5 years, as required by the university.

Conflicts of Interest:

The researcher is a NYS Credentialed Alcohol and Substance Abuse counselor at a non-for-profit agency on Long Island. Individuals that are current or past clients of the researcher and individuals that are current clients of the agency at the location that the researcher works at were considered as having a conflict of interest/dual role and were excluded from the study participation.

Contacts and Questions:

Contacts and Questions: You can ask questions of the researcher by R----------m@waldenu.edu if you want to talk privately about your rights as a participant or any negative parts of the study, you can call Walden University's Research Participant

Advocate at 612-312-1210. Walden University's approval number for this study is IRB will enter approval number here. It expires on IRB will enter expiration date.

You might wish to print and retain this consent form for your records. You may ask the researcher or Walden University for a copy at any time using the contact info above.

Obtaining Your Consent

If you feel you understand the study and wish to volunteer, please indicate your consent by stating, "I consent" on the audio recording prior to the interview.

Appendix C: Interview Guide

Opening questions were used to establish rapport and were semi-structured.

- Could you tell me a bit about yourself? (Prompts: job? Family? Hobbies? Interests?)

- Can you tell me a bit about your alcohol use? (Prompts: Age of first use? Can you tell me why you began to drink? Family history? Ever diagnosed? Longest period of abstinence? MAT? Self-help? Longest period of abstinence?)

Going into the pandemic, were you trying to maintain abstinence? (Prompts: How long had you been abstinent? What support did you utilize to maintain abstinence?)

Did there come a time during the pandemic that you relapsed? (Prompts: What events led up to the relapse? Were there any stressors that happened immediately before the relapse occurred? Was anyone with you at the time of the relapse? Can you describe the emotions that were happening at that time? Why do you think you drank at that time?)

What meaning did you prescribe to the events that led up to the relapse?

Were you tempted to drink prior to the relapse event?

What prevented you from drinking prior to the relapse event?

How do you feel about your relapse experience?

What meaning did you prescribe to the relapse event itself?