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Supporting the supportive parents: Community Reinforcement and Family Training for families affected by alcohol or substance use

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Supporting the supportive parents: Community Reinforcement and Family Training for families affected by alcohol or substance use
Thesis for doctoral degree (Ph.D.)

By

Ola Siljeholm

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To Hanna, Frank and Elis.

Everything is connected.

POPULAR SCIENCE SUMMARY OF THE THESIS

Problematic alcohol- or substance use not only affects the individual with the problem, but also causes second-hand harms to concerned significant others (CSOs) in close relationships. CSOs experience various negative effects, such as strained relationships, financial burdens, increased risk of violence, and feelings of shame, stress, and worry. Children affected by parental alcohol or substance use face psychological stress, neglect, and uncertainty, leading to negative social, educational, and psychological outcomes. Even limited problem drinking in parents can be perceived as stressful by children and increase risk factors. Despite that approximately 15 % of Swedish children grow up with a parent with drinking problems, the majority of these children never receive support. Children learn at an early age that alcohol related issues are best kept as a family secret which makes them hard to detect for personnel in schools or other representatives of the adult world. Another reason for lack of support is that parents rarely reach out to the social services out of fear of losing custody of their children (which is extremely rare).

The use of alcohol and other substances is at a peak in young adulthood, which increases the risks for several negative consequences, but very few young adults enter treatment for problematic substance use. Parents of adolescents and young adults often experience being blamed by others for causing the substance use which leads to shame and an unwillingness to seek support from others, whether it be friends, family members or professionals.

There is a lack of evaluated support programs for parents sharing a young child with a co-parent with drinking problems and for parents having a young adult with problematic substance use. For both of these contexts, the support program Community Reinforcement and Family Training (CRAFT) is deemed suitable to investigate due to the program's core concept of providing CSOs with concrete tools from cognitive behavior therapy (CBT) and communication strategies. These components have the possibility to change the environment surrounding the person with alcohol-/substance use, which could potentially lead to a decrease in alcohol or substance use and motivate co-parents and young adults to enter treatment. Hence, the overall aim of the thesis was to investigate the efficacy of different forms of CRAFT for parents in contexts where the program was not previously evaluated through four studies with diverse approaches.

In **study I** a web-based program called Supportive PArenting and Reinforcement (SPARE) was developed, directed at parents who do not have alcohol problems themselves but who share a child with a problem drinking co-parent. SPARE was compared to a control intervention that consisted of information material. SPARE included four modules with the aim of helping the participating CSOs to gain new strategies for handling the drinking co-parent, to take care of themselves and to focus more on their children. The program was based on CRAFT and on the Swedish parenting intervention ABC (Alla barn i centrum). The control group received information regarding alcohol, alcohol problems and where to find more help if needed. It was challenging to recruit participants, which lead to difficulties in analyzing potential differences between the two conditions. No improvements

regarding the children's mental health was found, but the CSOs in both groups reported that the co-parents drank less alcohol and that they felt better equipped to handle issues that arisen from co-parent drinking.

In **study II** interviews were performed with CSOs who had participated in the SPARE-program to get a better understanding of how the program had worked, what the CSOs thought about it and how they perceived that the co-parents' drinking problems had affected them. The interviews showed that the CSOs had been uncertain of whether they were entitled of support or if they had exaggerated. When they were acknowledged as living under stressful circumstances they felt relieved and empowered, and shifted focus away from the drinking co-parent. The CSOs mentioned that the relationship to their children had improved since they started to spend more time together with them and that this was one of the most appreciated effects. Finally, the CSOs appreciated the possibility to be anonymous since they didn't have to reveal themselves to any authority.

In **study III,** parents of young adults (18-24 years old) with problematic substance use who refused to engage in treatment for their substance use were recruited. The aim was to investigate if CRAFT led to more young adults entering treatment compared to a control intervention. Parents in the CRAFT-condition received eight sessions of individual support lead by experienced therapists at two outpatient clinics for adolescents and young adults in Stockholm, Sweden. Parents in the control condition received five sessions of manual-based counseling with experienced therapists at the same clinics. We found that 32 % of the parents managed to motivate their young adults into entering treatment before the 6 months follow up, with no differences between conditions. Regarding young adult alcohol-/substance use, parental self-efficacy and relationship happiness there were significant improvements in both conditions, with no differences between the groups.

In **study IV** interviews were performed with 10 parents who had undergone CRAFT in order to better understand their experiences of the program, what they had gained, and what they potentially thought was missing in the program. The interviews confirmed that the relationship with the young adults had improved by using new communication skills and focusing more on uplifting positive behaviors in their young adults, as oppose to arguing about negative issues. The parents felt that they had gained knowledge about relevant aspects on drug use and that they had received functional tools in order to feel better themselves and to affect the young adults' substance use, and in some cases motivating them to enter treatment. Overall, the parents appreciated the program but several expressed a need for better access to treatment at the times when the young adults are motivated.

Altogether, this thesis contributes with evidence that easy access interventions for CSOs who are also parents can provide the CSOs with tools that can cause a decrease in substance use and an increase in treatment seeking in the relative.

ABSTRACT

Background: Concerned significant others (CSOs) of individuals with problematic alcohol- or substance use show increased levels of psychiatric and somatic ill-health, social and economic problems and exposure to violence. Children growing up with at least one parent with problematic alcohol-/substance use have increased risks of a variety of problems, such as own substance use problems, low school performance, internalized and externalized problem behaviors and mental health problems. Parents of substance using adult children is an especially burdened group of CSOs with elevated strains due to the parent-child bond, experiences of stigma and feelings of shame. The prevalence of alcohol- and substance use is at a life-time high in young adulthood, which leads to increased risks for several physiological, psychological and social consequences. There is a treatment gap for young adults with problematic substance use, with large potential positive effects to gain from more young adults entering treatment at an earlier stage. There is a lack of evaluated support programs for CSOs who share a young child with a co-parent with problematic alcohol consumption, and also for parents of substance using young adults. For both of these contexts, variations of Community Reinforcement and Family Training (CRAFT) was deemed suitable to evaluate.

Aims: The overall aim of the thesis was to investigate the efficacy of different forms of CRAFT for parents in contexts where the program has not previously been evaluated. The specific aims were to investigate: i) the efficacy of a web-based self-delivered program combining CRAFT with a parenting training program; ii) reasons for seeking support as described by CSOs sharing a child with a drinking co-parent and to investigate how the CSOs described potential effects of the web-based program; iii) the efficacy of CRAFT for parents of treatment refusing young adults with problematic substance use; and iv) the experiences of CRAFT among parents of young adults with problematic substance use.

Methods: - Study I: A randomized controlled parallel-group superiority trial comparing the efficacy of the online intervention for CSOs sharing a child (3-11 y/o) with a drinking co-parent (N=37), to an active control group (N=39) receiving written psychoeducational material. Primary outcome was the children's mental health at 12 weeks, measured with the Strengths and Difficulties Questionnaire (SDQ). Linear mixed effect models were used to model time by group interaction effects.

- Study II: A qualitative design conducting semi-structured interviews with 13 female CSOs who had completed at least two of four modules in the program. Transcribed interviews were analyzed using conventional qualitative content analysis.

- Study III: A randomized controlled parallel-group superiority trial comparing CRAFT (n=58) to an active control group receiving counselling (n=55) for parents of treatment refusing young adults (18-24 y/o) with hazardous substance use, with young adult treatment seeking within 24 weeks as primary outcome. Setting was two outpatient clinics for adolescents and young adults in Stockholm, Sweden, subsequently via videoconference due to Covid-19. Outcome modelling was conducted using mixed effects models for all outcomes.

- Study IV: A qualitative design conducting semi-structured interviews with 10 parents who had participated in CRAFT in study III. Transcribed interviews were analyzed using thematic analysis.

Results: - Study I: There were no significant time by group effects on either the primary or secondary outcomes. The CSOs reported significant reductions in co-parent alcohol consumption and severity of dependence and showed improvements in parental self-efficacy for handling effects of co-parent alcohol consumption, but no differences between conditions.

- Study II: Main reasons for seeking support were wanting validation/emotional support and coping strategies for handling the co-parent, and negative perceptions of available support options for CSOs. Main perceived effects from the program were improved relationship to their children, increased own positive activities, and less adaptation to the co-parent.

- Study III: At the 24 weeks follow-up, 33 % of CRAFT-participants and 31 % of counselling participants had reported young adult treatment entry, with no difference between conditions. Both conditions reported clinically relevant reductions in substance use, but no change in parents' levels of depression, anxiety or stress, although from subclinical baseline levels.

- Study IV: The parents appreciated the accessible support at a time when they needed it due to feelings of shock and powerlessness, and they described communication strategies together with positive reinforcement as the two most helpful CRAFT-sessions. The parents expressed wanting more easily accessed treatment alternatives when the young adults were ready to enter treatment, and described difficulties to practice CRAFT-components due to changing life-circumstances and fear of aggravated health for their young adults.

Conclusions: The findings from study I-II showed that the support led to important improvements in consequences from co-parent drinking in both conditions. It was difficult to attract the target population, which led to limited statistical power, and no differences were found between conditions. CSOs who completed the program described anonymity as important for them to seek help, the program was perceived as empowering, and the relationship to their children had improved.

The findings from study III-IV showed that both CRAFT and the counselling program increased treatment seeking rates among young adults with problematic substance use. The lack of a non-active control condition reduces the possibility to draw definite conclusions regarding treatment efficacy. The parents found CRAFT to be valuable by providing strategies that resulted in an improved relationship to the young adults, a decrease in substance use, and in some cases young adult treatment entry. The results showed that CRAFT is suitable for the current population, but with some possible additions due to circumstances as part of the young adult developmental phase.

LIST OF SCIENTIFIC PAPERS

I. Siljeholm O, Lindner P, Johansson M, Hammarberg A. An online self-directed program combining Community Reinforcement Approach and Family Training and parenting training for concerned significant others sharing a child with a person with problematic alcohol consumption: a randomized controlled trial. *Addiction Science & Clinical Practice*, 2022;17(1). Doi: https://doi.org/10.1186/s13722-022-00332-3

II. Siljeholm, O. & Ekström, V. A shift in focus: Mothers' descriptions Of sharing a child with a co-parent with unhealthy alcohol use after participating in a support program. *Addiction Science & Clinical Practice*, 2023;18(12). Doi: https://doi.org/10.1186/s13722-023-00369-y

III. Siljeholm, O., Edvardsson, K., Bergström, M., & Hammarberg, A. Community Reinforcement and Family Training versus counselling for parents of treatment refusing young adults with hazardous substance use: A randomized controlled trial. [Accepted with revisions in Addiction]. Department of Clinical Neuroscience, Centre for Psychiatry Research, Karolinska Institutet

IV. Siljeholm, O., Eckerström, J., Molander, O., Sundbye, J., & Hammarberg, A 'Before, we ended up in conflict, now we can provide support' Experiences of Community Reinforcement and Family Training (CRAFT) for parents of young adults with hazardous substance use. [Under review]. Department of Clinical Neuroscience, Centre for Psychiatry Research, Karolinska Institutet

SCIENTIFIC PAPERS NOT INCLUDED IN THE THESIS

- Lindner P., Siljeholm, O., Johansson, M., Forster M., Andreasson S., & Hammarberg A. Combining online Community Reinforcement and Family Training (CRAFT) with a parent-training programme for parents with partners suffering from alcohol use disorder: study protocol for a randomised controlled trial. BMJ Open. 2018;8(8):e020879. Doi: https://doi.org/10.1136/bmjopen-2017-020879

CONTENTS

LIST OF ABBREVIATIONS

ACRS	The Adult-Child Relationship Scale
AUD	Alcohol Use Disorder
AUDIT-C	Alcohol Use Disorders Identification Test (Consumption)
CAN	Centralförbundet för alkohol- och narkotikaupplysning (Swedish Council for Information on Alcohol and Other Drugs)
CAP	Children Are People too
CBT	Cognitive Behavior Therapy
COREQ	The Consolidated Criteria for Reporting Qualitative Research
CRAFFT	Car, Relax, Alone, Forget, Friends, Trouble
CRAFT	Community Reinforcement and Family Training
CSO	Concerned Significant Other
CSQ	Client Satisfaction Questionnaire
CST	Coping Skills Training
DSM 5	Diagnostic and Statistical Manual of mental disorders, 5th revision
DUDIT	Drug Use Disorder Identification Test
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EQ5D-VAS	EuroQoL-5D Visual Analogue Scale
FMQ	The Family Member Questionnaire
GCP	Good Clinical Practice
ICBT	Internet Cognitive Behavior Therapy
ICD 10	International Classification of Diseases, 10th revision
ITT	Intention-to-treat principle
PM	Psychoeducative (information) Material
PSE	Parental Self-Efficacy
PSE-A	Parental Self-Efficacy to handle co-parent Alcohol consumption
RCT	Randomized Controlled Trial
RHS	Relationship Happiness Scale
SAHMSA	Substance Abuse and Mental Health Services Administration
SDQ	The Strengths and Difficulties Questionnaire
SMAAP	Stress Management and Alcohol Awareness Program
SPARE	Supportive PArenting and REinforcement
SSICS-Model	The Stress-Strain-Information-Coping-Support-Model
SUD	Substance Use Disorder
TLFB	TimeLine FollowBack
WHO	World Health Organization

PREFACE

My first encounter with Community Reinforcement and Family Training (CRAFT) was as a psychology student. I was introduced to the program during a pilot trial in Sweden, where its core concept of providing tools for behavior change to concerned significant others (CSOs) intrigued me. It shifted my perspective on substance use problems from an individualistic perspective, making me realize the impact of the environment on the substance user. I further learned that CSOs, a large group affected by second-hand effects of a relative's substance use, had received little attention in previous research. However, over the past decade, there has been increasing recognition of the harms caused by substance use and the emergence of support programs for CSOs, including children affected by parental alcohol and substance use. The research evidence for psychosocial intervention for CSOs is still limited due to methodological differences, small sample sizes, and variations in outcome measures. Especially, support programs for CSOs who are also parents are still lacking, and it is the aim of this thesis to contribute to an increased knowledge on interventions directed at this group of CSOs.

I believe anyone could become a CSO, as there is no certain way to avoid problematic substance use, but I believe that CSOs can have the power to minimize risks and to influence their loved ones once a problematic use has emerged. But before advancing any further, it is important to establish that *CSOs are never responsible for the drinking or substance use that their relatives exhibit*. This is bottom line. The user is always responsible for his/her own use. However, all substance use happens in a context, and CSOs have a potential to alter the context, especially if provided with relevant education and functional tools. Hence, this thesis is written within a tradition of hopefulness and empowerment for CSOs. Although the endeavor of CSOs entering CRAFT might not always be enough, it is never wrong to try and help someone you love.

Ola Siljeholm, Stockholm, August 2023

1 LITERATURE REVIEW

1.1 ALCOHOL AND SUBSTANCE USE

In this thesis, *problematic alcohol- or substance use* will be used as collective terms for patterns of consumption which lead to negative effects for the using individual or for concerned significant others (CSOs) affected by the substance use. If reporting on studies where participants have been diagnosed with Alcohol Use Disorder (AUD) or Substance Use Disorder (SUD) according to DSM-5, or alcohol-/substance dependence according to ICD-10, these diagnostic terms will be used.

1.1.1 Alcohol consumption; prevalence and consequences

Alcohol consumption is prevalent globally, with the majority of individuals maintaining a non-problematic intake (WHO., 2018). However, a portion of the population develop AUD or drink heavily over time causing, injuries, medical harms and social consequences. Problematic alcohol use results in three million deaths every year (5.3 % of all deaths, and 13.5 % of all deaths in the age group 20-39) and contributes as a causal factor to over 200 disease and injury conditions (Carvalho, Heilig, Perez, Probst, & Rehm, 2019; WHO, 2022). In Sweden, approximately 15 % of men and 12 % of women consume alcohol above levels of risk drinking according to the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C (Bergman & Källmén, 2002; Bush, 1998)), and the prevalence of AUD in 2021 was 13 % in men and 9 % in women (CAN, 2022a; Kallmen, Wennberg, Ramstedt, & Hallgren, 2015). Problematic alcohol consumption is highest among young adults (17-29 years), and the development over the last decades show a decrease in consumption for men and an increase for women (Kallmen et al., 2015; Källmén, Berman, Elgán, & Wennberg, 2019). The 2021 prevalence of AUD in the age group 17-29 years was 21 % in men and 22 % in women (CAN, 2022a).

1.1.2 Substance use; prevalence and consequences

The occurrence of substance use, i.e. other narcotic substances than alcohol, in the last year vary vastly in different populations, with a worldwide prevalence assessed to 5.5 % (UN, 2019). Regarding SUD, prevalence worldwide is approximately 1 %, and in Sweden around 2 % (CAN, 2022a; UN, 2019). Among substance related deaths, opioids account for a majority of substance related deaths (EMCDDA, 2020; Folkhälsomyndigheten, 2023).

Similar to alcohol consumption, the prevalence of substance use is at a peak in young adulthood, for some individuals leading to problematic use or SUD with increased risks for negative physiological, psychological and social consequences and premature death (Arnett, 2005; CAN, 2022a; Folkhälsomyndigheten, 2023; Grant et al., 2016). The latest Swedish figures showed a prevalence of 14 % for any substance use during the last year among young adults between age 17-29 (CAN, 2022a). Cannabis was the most common substance (10 %), while 5 % had used other substances (e.g. cocaine, amphetamines, opiates, hallucinogens) and 4 % reported use of non-prescribed narcotic pharmaceuticals

(analgesics) (CAN, 2022a). The prevalence of SUD in the age group 17-29 years was around 4 % for both men and women (CAN, 2022a).

1.1.3 Treatment gap

Although the problematic use of both alcohol and other substances are very common worldwide, there is a large treatment gap with only around 10-20 % of affected individuals entering treatment (Carvalho et al., 2019; Degenhardt et al., 2017; Kirby et al., 2015; Ozechowski & Waldron, 2010; SAHMSA., 2020). Taboo and stigma are associated with problematic alcohol and substance use, and are known barriers to treatment (Kilian et al., 2021; Wallhed Finn, Mejldal, & Nielsen, 2023), but lack of will to stop using substances is also a contributing factor (Paquette, Daughters, & Witkiewitz, 2022). Treatment entry for problematic alcohol- and substance use is associated with numerous benefits for the using individual (Dawson, Grant, Stinson, & Chou, 2006; Paquette et al., 2022), as well as for CSOs who are affected by the substance use of a close relative (Smith & Meyers, 2004).

Regarding young adults, the use of alcohol and other substances cause a large part of the disease burden but less than 10 % ever enter treatment, due to for example lack of motivation, rejection of treatment options, stigma or shame (Earnshaw et al., 2018; Kirby et al., 2015; Lim et al., 2012; Patel, Flisher, Hetrick, & McGorry, 2007; SAHMSA., 2020). Reasons to enter treatment mentioned among those who do, are often parental pressure or support, and caring for the parental relationship (Cleverley, Grenville, & Henderson, 2018; Wagner et al., 2017).

1.2 CONCERNED SIGNIFICANT OTHERS

For every individual with problematic drinking or substance use, it is conservatively estimated that at least one additional person is adversely affected (Bloomfield, Jensen, & Ekholm, 2019; Orford, Velleman, Natera, Templeton, & Copello, 2013). Second-hand effects from substance use are present at both a societal level through for example unintentional injuries, deaths in traffic accidents, material damage, and economic losses, and at a personal level for CSOs through psychological, physical, emotional, economic and relational consequences (Andréasson, 2015; CAN, 2018; Sundin, 2022). In a Swedish survey study, 26 % of participants stated to have a person in their lives that they perceive as drinking too much. Among these, almost half indicated to have been affected negatively by the drinking, which corresponds to 11.7 % in the population. Regarding other drugs, 15 % of participants stated to have a person in their lives using illicit substances, of which 25 % were negatively affected (3.8 % in the population) (CAN, 2022b). Another Swedish study reported that 5 % of the women and 2 % of men have experienced severe harm from a known drinker (Sundin, Galanti, Landberg, & Ramstedt, 2020).

The prevalence of psychiatric and somatic conditions among CSOs to individuals with substance use problems is higher than in the general population (Bischof et al., 2022; Casswell, You, & Huckle, 2011; Di Sarno et al., 2021; Ray, Mertens, & Weisner, 2009).

CSOs are at an increased risk of experiencing distress, substance use disorders, depression, trauma, and higher healthcare costs (Bischof et al., 2022; Ray et al., 2009; Tempier, Boyer, Lambert, Mosier, & Duncan, 2006). The home environment when co-habiting with a person with AUD has been described with metaphors such as *warzone* and *prison* (Hellum, Bilberg, & Søgaard Nielsen, 2021), and being a parent of a substance using adult child involves a constant worry that something horrible will happen to their child (St-Amant & Schwind, 2022). Hence, being a CSO to a relative with problematic substance use causes distress in several ways, and many CSOs need support to handle their stressful circumstances.

1.2.1 A short historical view of concerned significant others

Traditionally, the prominent view on CSOs has been as *codependent*, a concept with a history starting in the 1940s, describing behavioral patterns, characteristics and attitudes of family members of alcoholics (Cermak, 1986). Typically for the view of this time, the CSOs - especially the partners (most often wives) - were considered a part of the problem since they acted in ways that sustained, or even enhanced, the use of alcohol in the drinking partner (Whalen, 1953). Within this tradition, CSOs are told that in order to recover from their codependency, they must accept being helpless regarding their relatives' alcohol use disorder and that they must "detach" from their relative (Timko, Young, & Moos, 2012). The codependency construct has been criticized from several perspectives over the years, mainly by opponents of its pathologizing nature (e.g. Copello, Templeton, Orford, & Velleman, 2010b; Hurcom, Copello, & Orford, 2000; Stafford, 2001).

Another framework for how to conceptualize CSOs experiences have emerged gradually during the last five decades through numerous studies of persons with different relationships to someone with a problematic alcohol- or substance use in diverse cultures (Orford, 2017; Orford et al., 1998). In this view, CSOs are ordinary people living under difficult circumstances, gradually worsening as the substance use of the relative progresses, which causes stress and strain (Orford et al., 1998). The CSOs try to respond to their stressful situations best they can with a variety of more or less functional behaviors or coping strategies. From this research, the Stress-Strain-Information-Coping-Support model, which will be described later, was developed (Copello et al., 2010b; Orford et al., 2013).

Based in a similar non-pathological perspective on CSOs, research highlighting the role of the environment surrounding a person with problematic alcohol or substance use emerged during the 70s. The rational is that the environment, or *community* (i.e. for example the CSOs) have access to, and can control, certain *contingencies* (possible future events or circumstances following from a behavior), which have the possibility to affect the relative's substance related behaviors (Azrin, 1976; Roozen & Smith, 2021). This research laid the foundation for a program that eventually was developed into Community Reinforcement and Family Training (CRAFT) (Smith & Meyers, 2004)

Hence, different approaches have been developed over the last decades with somewhat differing basic assumptions, but all with the aim of helping CSOs with coping and emotional support. In this thesis the SSICS-model will serve as the basis for how to

understand the strains that CSOs experience, and CRAFT will be the focus among the support interventions.

1.2.2 The Stress-Strain-Information-Coping-Support Model

The Stress-Strain-Information-Coping-Support model (figure 1), is a model for conceptualizing the effects of a relative's substance use on CSOs (Copello et al., 2010b; Orford et al., 2013).

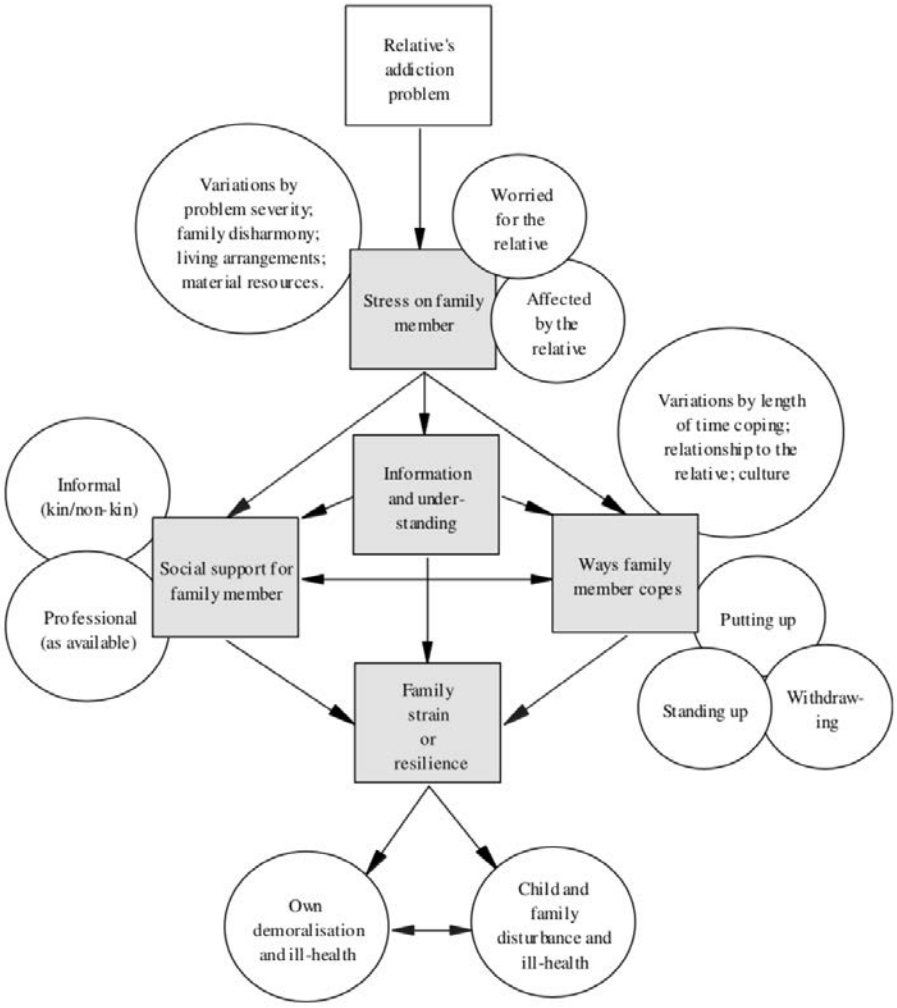

Figure 1. The Stress-Strain-Information-Coping-Support Model. [1]

[1] Reprinted from Social Science & Medicine, Vol 78, Orford, J., Velleman, R., Natera, G., Templeton, L., & Copello, A., Addiction in the family is a major but neglected contributor to the global burden of adult ill-health, 70-78., Copyright (2013), with permission from Elsevier.

The first component of the model is *stress*, recognizing that being a CSO is stressful, and that stress varies between individuals, for example due to severity of substance use, family (dis)harmony or levels of CSOs' worry about the relative. All CSOs have different ways of facing or responding to stress, i.e. different ways of *coping*. The model proposes three coping styles: *tolerant-inactive*, *engaged* and *withdrawal* coping styles. Tolerant-inactive coping includes behaviors such as making excuses for the using relative, taking the blame or covering up for the relative. An engaged coping style includes CSOs trying to restrict the substance use by making rules regarding substance use, and pleading or being upset. CSOs with a withdrawal coping style tend to distance themselves from situations when substance use occurs, focusing more on their own lives and leaving the relative to him-/herself.

The component social *support* underscores the importance of both formal and informal support for CSOs as a key resource for coping. Support is hence closely related to coping styles since CSOs are affected by other individuals/networks in their vicinity, and the emotional, informational and material support they provide. The next component highlights that *information* about substance use, its potential effects, different substances or alcoholic beverages etc., is crucial for CSOs to make sense of addiction or dependence and what their relative is struggling with. The final component of the model is *strain* which is the direct consequences of the stressful effects caused by the relative's substance use, mediated by coping styles, social support and information, plus potentially other ailments such as increased levels of CSOs mental health problems.

1.3 PARENTS AS CONCERNED SIGNIFICANT OTHERS

1.3.1 Concerned Significant Others being parent(s) of a substance using adult child

Being a parent of a young adult with substance use disorder can be a particularly challenging CSO relationship due to the strong emotional and social bonds involved, together with stress stemming from having a child who is exposed to constant risk of suffering or even death (Orford et al., 2013; Richert, Johnson, & Svensson, 2018).

The view in this thesis is that cultural and social beliefs about what good parenting is leads to individuals comparing how they perceive their own parenting to the societal view. Several studies have pointed to how psychological theories such as Bowlby's attachment theory, have contributed to societal views on childrearing by highlighting the role of parenting as an explanation for developmental issues and mental health problems in children (e.g. Corrigan, Watson, & Miller, 2006; Richert, Svensson, & Johnson, 2021). According to attachment theory, mothers in particular are often singled out and blamed for their children's health issues and deviant behavior. Another theory contributing to the social view of blaming parents is Winnicott's concept "good enough mother," attributing potential psychopathologies in children to mothers (Jackson, 2018; Richert et al., 2021).

Mothers have generally been perceived as the primary caregiver (Ekström & Johansson, 2020; Elvin-Nowak & Thomsson, 2001), and mainly mothers have participated in qualitative studies with parents of a substance using adult child (Ahmad Shahril, Arshat, & Adnan, 2022; Orford, 2017; Richert et al., 2021; St-Amant & Schwind, 2022). The societal view place responsibility on each individual parent to raise, care for, and protect their children, which can lead to parental blame when children face problems or challenges (Devaney, 2017; McCann & Lubman, 2018a, 2018b). Even in adulthood, parents (especially mothers) experience being held accountable by others for their children's substance use problems due to the perceived influence of the childhood environment and early relationships (Jackson, 2018). For example, a Swedish study focusing on parents of adult children with drug problems found that feelings of guilt and shame were prevalent in the group, with mothers experiencing these emotions to a greater extent than fathers (Richert et al., 2021).

Caring for an adult child with substance use problems causes many CSOs to cut down on interactions with other family members and friends which narrows their social lives, leading to increased isolation (Slaunwhite, Ronis, Sun, & Peters, 2017). The conflict rate in families affected by an adult child's substance use is often high, regarding e.g. financial issues, substance use and boundaries (Copello et al., 2010b; Sussman & Arnett, 2014). Many parents report feelings of powerlessness and hopelessness after having tried different approaches to affect their child's substance use without any success (Jackson, 2018; Richert et al., 2018). Also common are experiences of anticipatory grief, manifested as a constant fear of receiving devastating news (St-Amant & Schwind, 2022). Additionally, parents express feelings of grief and loss due to lost contact, unfulfilled expectations, or the death of their child (Jackson, 2018; Richert et al., 2018; Wilkens & Foote, 2019).

1.3.2 Parents of young adults as important agents

Although many parents perceive that their ability to affect their children decrease with the child's age, several studies show that parental attitudes towards substance use continue to matter (Glatz & Koning, 2016; Koning, Doornwaard, Van Der Rijst, De Houwer, & Vollebergh, 2022). The most support is found regarding parental use of strict alcohol-specific rule setting for delaying the onset of drinking in adolescents (e.g. Van Der Vorst, Engels, Meeus, & Deković, 2006), but preliminary evidence indicate that alcohol-specific rules can influence also adolescent use of cannabis (Koning, de Looze, & Harakeh, 2020) and levels of adolescent alcohol consumption (Koning et al., 2022). Lastly, parental support and/or pressure, and the importance of the relationship to the parents, is among the most common reasons mentioned by young adults who enter substance use related treatment (Cleverley et al., 2018; Cornelius, Earnshaw, Menino, Bogart, & Levy, 2017).

In essence, support programs directed at parents of substance using young adults can be justified as an aid to handle emotional, financial and social distress (Copello, Templeton, Orford, & Velleman, 2010a; Orford, Copello, Velleman, & Templeton, 2010; Richert et al., 2018). Simultaneously, there is a need to narrow the treatment gap for substance using young adults, and research suggests suggest that interventions with the double aim of

providing support for the parents *and* to promote young adult treatment seeking is a potentially effective approach (Cleverley et al., 2018; Hogue et al., 2021; Kirby et al., 2015; Wagner et al., 2017). Despite their need for support, no structured support program for parents of substance-using adult children was found in a recent systematic review (McGovern et al., 2021).

1.3.3 Concerned Significant Others sharing a child with a drinking co-parent

Little is known about the experiences of co-parents of individuals with problematic substance use. Previous research has shown that partners of those with AUD report lower relationship satisfaction, particularly if they share children (Foulstone, 2016). Additionally, non-drinking partners rate the effects of their spouse's alcohol use as more severe than drinking partners (Hussaarts, 2012). In a Swedish qualitative study, mothers who shared a child with a father who had AUD described experiences of stress, unreliable and absent fathers, mood swings, violence, constant worry, and the need for support (Ekström & Johansson, 2021). Alexanderson & Näsman (2017) interviewed 23 children who had one parent with a known substance use problem and one parent who did not have a substance use problem. The children found "the other parent" as protective in certain aspects, but often not protective enough to keep them from experiencing any harmful effects of the parents' substance use (Alexanderson & Näsman, 2017).

Research on female CSOs sharing a child with a problem drinking co-parent has shown high levels of stress and strain and that all aspects of life were negatively affected (Orford, 2017; Velleman & Templeton, 2007). Other studies describe female CSOs experiencing multiple burdens, such as caring for both the co-parent and children, being responsible for the household, trying to compensate for the unreliable and absent father, and feeling powerless (Ekström & Johansson, 2020; Orford et al., 2013) – and that they need support to deal with the challenges they face (Weimand, Birkeland, Ruud, & Høie, 2020).

Prior research has demonstrated promising outcomes with a dual-treatment approach which integrates parenting interventions and substance use treatment for parents with problematic substance use (Neger, 2015). However, no studies have been identified that examined a dual-treatment approach integrating parenting interventions and CSO-interventions for non-drinking CSOs.

1.4 SUPPORT PROGRAMS FOR ADULT CONCERNED SIGNIFICANT OTHERS

Interventions for CSOs can broadly be divided into interventions where the relative with problematic substance use is included (e.g. couples' therapy or systemic family interventions) or unilateral interventions for CSOs (Kourgiantakis, Ashcroft, Mohamud, Fearing, & Sanders, 2021; McGovern et al., 2021). Unilateral approaches most often include at least one of three objectives: (1) helping the CSO to induce behavior changes of the substance using relative, (2) enhancing the relationship, and (3) mitigating the adverse effects of substance use via changes in coping strategies (Kirby & LaMonaca, 1999).

1.5 COMMUNITY REINFORCEMENT AND FAMILY TRAINING

1.5.1 CRAFT - theoretical assumptions and history

The community reinforcement perspective to treatment of alcohol use disorder started in the 1970s with the work of the behavioral modification researcher Nathan H Azrin and colleagues. At the very basis of this perspective is operant learning theory, positing that behaviors evolve as a result of its immediate consequences. Consequences perceived as positive and familiar will lead to an increased probability of a behavior occurring again in a similar context, and consequences perceived as negative will decrease the probability of the behavior occurring again (Cooper, Heron, & Heward, 2020; Skinner, 1958).

Azrin and colleagues developed a treatment intervention for individuals with AUD called Community Reinforcement Approach (CRA) with a basic idea to rearrange significant personal and community-based contingencies to act as reinforcers of positive behaviors (Azrin, 1976). In the original program, therapists for example helped to prime the client to perform recreational activities that would compete with drinking and introduced marriage and family counseling in order for the client to be involved more in pleasurable family activities (Azrin, 1976; Azrin, Naster, & Jones, 1973).

Eventually, an approach was invented which invited the CSOs (wives) to counseling also when the drinking husband did not want to come to treatment (Sisson & Azrin, 1986). This intervention involved teaching the CSOs strategies such as providing positive consequences for abstaining from drinking, scheduling alternative activities, allowing natural negative consequences of drinking to occur, and managing hazardous situations for both the drinker and the family (Sisson & Azrin, 1986). From this approach, a comprehensive program was developed into Community Reinforcement and Family Training (CRAFT) (Smith & Meyers, 2004).

1.5.2 The CRAFT program

Community Reinforcement and Family Training (CRAFT) is a manualized support program developed to address the needs of CSOs who aim to encourage their substance-using relatives to seek treatment (Meyers, Miller, Hill, & Tonigan, 1998b). CRAFT draws upon core principles of behavioral therapy and focuses on improving the quality of life for CSOs, reducing substance use in the relative, and facilitating treatment engagement. In Sweden, CRAFT is recommended for CSOs who aim to motivate their relative to enter treatment in The National guidelines for treatment and support of addiction by the National Board of Health and Welfare (Socialstyrelsen, 2019).

The CRAFT program embraces three main goals (Smith & Meyers, 2004): First, a focus on increasing treatment engagement by empowering CSOs to effectively propose and advocate for treatment seeking. Second, to decrease the alcohol or drug consumption of the substance-using relative by equipping CSOs with skills to modify their own behavior. This involves minimizing the positive consequences of substance use, increasing positive

consequences of sober and healthy activities, and fostering clear and positive communication. Third, to enhance the quality of life for CSOs by promoting engagement in recovering activities.

The CRAFT program consists of the following eight components:

1. Motivational Strategies: Involves introducing the CRAFT program to the CSOs and fostering positive expectations for engagement in the program.
2. Functional analysis of the relative's substance-using behavior, by which means identifying the triggers contributing to the relative's substance problem. Based on this analysis, strategies are developed for the CSOs to address these triggers effectively.
3. Domestic violence precautions: Includes assessing the potential for domestic violence, providing training on recognizing early signs of violence, and devising a safety plan.
4. Communication training: Examines the CSOs' current communication patterns and aims to enhance skills in positive communication through techniques such as role-playing.
5. Positive reinforcement training: To identify and utilize small rewards as positive reinforcement for the relative, reinforcing healthy and sober behaviors.
6. Discouraging substance use: Emphasizes the importance of withdrawing reinforcement during episodes of substance use to allow for the natural negative consequences of the relative's behavior to occur.
7. CSOs own quality of life: Focus on enhancing the CSOs' own well-being and quality of life through self-reinforcement techniques.
8. Suggestion of treatment to the relative: Identifying the optimal time to suggest treatment to the relative, preparing CSOs to handle and overcome resistance, providing information about available treatment options, potentially developing a plan for treatment entry and for the relative’s continued participation in treatment.

1.5.3 Scientific support for CRAFT

Several studies have examined the efficacy of CRAFT in promoting treatment engagement in the relative and well-being among CSOs. The most recent meta-analysis incorporated findings from 14 studies that utilized different delivery formats of CRAFT, including self-help books, internet-based programs, individual face-to-face sessions, and group sessions (Archer, Harwood, Stevelink, Rafferty, & Greenberg, 2020). These studies encompassed CSOs of individuals with various addiction problems, such as gambling disorder, AUD and SUD, with a total of N=691 participants. The meta-analysis revealed treatment engagement rates between 12.5 % and 86 %, with notable differences in rates between studies targeting gambling addiction (12.5-23 %) and studies targeting different SUDs (40-86 %). Regarding CSOs mental health, CRAFT and all studied active intervention groups reported similar improvements (Archer et al., 2020). Notably, almost all CRAFT-trials reporting treatment

entry rates above 40 % have offered treatment possibilities for the substance using relatives, either with the same team of therapists providing CRAFT or linked to another pre-specified treatment provider (Archer et al., 2020). In these studies, the CSOs could book treatment appointments directly for their relative, which may have inflated treatment seeking rates compared to studies where no such possibilities were offered (Archer et al., 2020; Kirby et al., 2015; Waldron, Kern-Jones, Turner, Peterson, & Ozechowski, 2007).

1.5.4 CRAFT for parents

Three non-randomized trials have investigated CRAFT for parents of substance using adolescents/youths. One trial studied 12 sessions of face-to-face delivered CRAFT for parents of 42 treatment refusing substance using youths (14-20 years) (14-20 years) (Waldron et al., 2007). Within six months, 71 % of the youths entered treatment, with treatment entry coordinated by the parents' and adolescents' therapist and study personnel in order to facilitate engagement. Secondary findings were decrease in number of days with marijuana use, and improvements in parents' symptoms of depression and anxiety.

In a small pilot trial including eight parents of substance using adolescents (14-18 y/o), 12 sessions of a program comprising CRAFT and Parent Management Training-components were offered (Kirby et al., 2015). The study reported that 67 % of the adolescents engaged in treatment to address their substance use after first receiving more general counselling at the clinic where the trial was conducted.

In the third study (Bisetto Pons, González Barrón, & Botella Guijarro, 2016) ten weekly CRAFT group-sessions were delivered to parents of substance using youths (age not stated) with parental mental health as primary outcome. Post-treatment scores were compared to a group of "healthy controls", consisting of parents who did not have a substance using child. After receiving CRAFT, the parents of the substance using youths reported significant improvements in self-esteem, depression and state anger, and their post-treatment scores corresponded with the "healthy control-group". Lastly, 60 % of the youth had sought treatment during the study period.

To summarize, there is preliminary evidence that CRAFT for parents may enhance treatment seeking for adolescents and young adults, but no previous RCT has been performed. There is also a lack of studies without the possibility of referring the young adults to pre-specified treatment providers, hence investigating CRAFT for young adults under more ecologically valid conditions.

1.5.5 Qualitative evaluations of CRAFT

Two previous qualitative studies examining the experiences of participants in CRAFT-programs have been identified, performed in different contexts regarding for example delivery modes, program content, settings, and participants (Hellum, Bilberg, Bischof, & Søgaard Nielsen, 2021; Osilla et al., 2018). Hellum et al (2021) interviewed 11 female

CSOs of individuals with AUD after participating in a trial of CRAFT delivered within the Danish Addiction Service (Hellum, Bilberg, Bischof, et al., 2021). Osilla et al conducted a feasibility trial were CRAFT was administered using a web-based design to spouses of military veterans concerned about their partners alcohol consumption, and interviews were performed with eight participants (Osilla et al., 2018). Both studies reported that the positive communication component of CRAFT was the most helpful, followed by reinforcement of positive behaviors (Hellum, Bilberg, Bischof, et al., 2021; Osilla et al., 2018). Hellum et al also concluded that CRAFT was perceived by the CSOs as helpful in improving quality of life and that CSOs were helped by a better understanding of AUD (Hellum, Bilberg, Bischof, et al., 2021). In sum, there is a scarcity of studies on participants' experiences of CRAFT, and no previous examples of articles reporting perceptions of CRAFT among parents of young adults with problematic substance use or among CSOs sharing a child with a drinking co-parent.

1.6 OTHER UNILATERAL SUPPORT PROGRAMS FOR ADULT CONCERNED SIGNIFICANT OTHERS

1.6.1 Al-Anon facilitation therapy

Al-Anon facilitation therapy (AFT) is a widely used program for CSOs based on the 12-step model (Timko, Laudet, & Moos, 2016). AFT encourages CSOs to participate in Al-Anon processes and group meetings, emphasizing acceptance of powerlessness over the relative's drinking and focusing on their own well-being (Miller, 1999; Timko et al., 2016). Several studies demonstrate that AFT improves CSOs' quality of life, coping skills, and reduces depressive symptoms (O'Farrell & Clements, 2012; Roozen, de Waart, & van der Kroft, 2010; Timko et al., 2016). In Sweden, AFT is commonly used and recommended in the national guidelines for addiction treatment (Socialstyrelsen, 2019).

1.6.2 The Johnson Institute Intervention

The Johnson Institute Intervention (JII) is widely known due to its portrayal in TV programs but is not commonly used outside the USA (Roozen et al., 2010; White, 2007) and has served as active control in several RCTs on CRAFT (Archer et al., 2020). JII involves a confrontational approach where multiple CSOs express their hurt and demand the relative to enter treatment (Johnson, 1986). However, the JII-approach contradicts evidence-based motivational principles, and many family members do not follow through with its procedures (Meyers et al., 1998b; O'Farrell & Clements, 2012; White, 2007). There is limited evidence that the Johnson Intervention yields positive outcomes for the family members themselves, (Roozen et al., 2010).

1.6.3 The 5-step method

The 5-step method is based on the SSICS-model, and includes emotional support, investigation of social networks, exploration of coping responses, educational aspects regarding addiction and alcohol/drug use and exploration of need for further help (Copello et al., 2010b). The 5-step method has been evaluated in one randomized controlled trial (RCT) (N=137) and several studies using pre-post designs in various countries, including the UK, Mexico, Italy, India and the Netherlands (Copello et al., 2010a; Van Beek, Velleman, De Bruijn, Velleman, & Goudriaan, 2023). In all studies, tailored questionnaires constructed by the research groups has been applied in order to measure change in the different components and dimensions in the SSICS-model have been used to evaluate effects and associations. The main results overall show a decrease in stress from baseline to follow up (12 weeks) reported by the CSO, with effects lasting up to one year post treatment (Copello et al., 2010a). Measurement on family burden is routinely used in clinical practice, and there are preliminary promising results from clinics utilizing the 5-step method in several countries (Velleman, 2023).

1.6.4 Coping skills training

In Coping Skills Training (CST), CSOs apply a problem-solving model to drinking-related situations (Rychtarik & McGillicuddy, 2005). Two RCTs have shown reduced depression, increased coping skills, decreased drinking, and improved partner relationships with CST (Rychtarik & McGillicuddy, 2005; Rychtarik, McGillicuddy, & Barrick, 2015). In a Swedish RCT, CST improved coping, psychiatric symptoms, and hardship at 12- and 24-month follow-ups. However, CST was not superior to control conditions receiving CBT in group or information material (Hansson, 2004; Zetterlind, Hansson, Aberg-Orbeck, & Berglund, 2001).

1.7 SYSTEMATIC REVIEWS AND META ANALYSES OF INTERVENTIONS FOR ADULT CSOS

Several systematic reviews (some including meta-analyses) from the last years have examined interventions involving CSOs to identify available support programs and to assess their effects (Kourgiantakis et al., 2021; McGovern et al., 2021; Merkouris, Rodda, & Dowling, 2022; Rushton, Kelly, Raftery, Beck, & Larance, 2023; Shorter et al., 2023).

Results from the articles are mixed due to differences in methodologies and scopes. Overall, the reviews provide support that CSO-interventions improve knowledge about addiction, CSO-related psychosocial factors such as depression, life satisfaction and coping skills, both individually- and group delivered (Merkouris et al., 2022; Rushton et al., 2023; Shorter et al., 2023) and encourage treatment involvement for the relative with substance use (McGovern et al., 2021; Merkouris et al., 2022). Disparities in study designs, intervention types, outcome assessments and bias risk limited possibilities for drawing firm conclusions, and in several of the articles, the authors emphasized the need for a common

theoretical framework and harmonization of outcomes (Kourgiantakis et al., 2021; Rushton et al., 2023; Shorter et al., 2023).

1.7.1 Barriers to seeking support for adult concerned significant others

Several kinds of barriers exist for CSOs to seek support. There can be practical barriers such as lack of time, economic constraints, geographical availability and child-care issues (Wilson, Rodda, Lubman, Manning, & Yap, 2017). Other barriers include availability of programs, and that the help available is contingent on the participation of the substance using relative (Alexanderson & Näsman, 2017; Ekström & Johansson, 2021). Previous negative experiences of support from authorities, often due to professionals' lack of relevant knowledge, make CSOs reluctant to seek support again (Ekström & Johansson, 2020; McCann & Lubman, 2018a; Richert et al., 2021). Several CSOs also live under a real threat of being exposed to violence as a reaction from a relative reacting negatively to the fear of being exposed (Orford, Velleman, Copello, Templeton, & Ibanga, 2010).

Many CSOs experience *public stigma*, meaning that others exhibit negative attitudes towards a certain group of people perceived to have devalued characteristics (Corrigan & Rao, 2012; Wallhed Finn et al., 2023). CSOs suffer from the public stigma connected to substance problems merely by being associated with a relative with problematic substance use, a concept called *courtesy stigma* (Goffman, 1963*)* (sometimes *stigma by association*) (e.g. Liahaugen Flensburg, Richert, & Väfors Fritz, 2022; McCann & Lubman, 2018b). Stigmatization from both informal and formal contexts hinder CSOs from revealing their situation to others (Liahaugen Flensburg et al., 2022; McCann & Lubman, 2018a; Richert et al., 2018). Experiences of stigmatization appear to be especially prominent for parents of substance using adult children (and adolescents) (Wilkens & Foote, 2019) with parents describing being blamed by both formal and informal contacts for causing the substance use (Corrigan et al., 2006; Wilkens & Foote, 2019).

Public attitudes can become internalized by the group with the "negative" characteristic, leading to *self-stigma* (Corrigan & Rao, 2012; Corrigan et al., 2006). The self-stigma can induce shame and fear of how others will react, which is contributing to the perception by many CSOs that substance use problems is best kept a family secret and refrain from seeking help (Orford et al., 2013; Richert et al., 2021).

Barriers to treatment can vary depending among different cultures. In many countries the absence of formal social support, lack of a social security system, brutal treatment by police or other institutions, or fear of social reprimands if traditional family responsibilities are broken can limit the CSOs possibilities to seek help (Ahmad Shahril et al., 2022; Orford, 2017; Orford et al., 2013).

There is a scarcity of studies regarding which factors facilitate support seeking for CSOs, but web-based counseling and previous positive help-seeking experiences has been reported to lower barriers and serve as a first step towards further support (McCann & Lubman, 2018a; Wilson et al., 2017). Reduced public and self-stigma regarding alcohol and

substance use has been linked to increased treatment seeking in individuals with AUD (e.g. Wallhed Finn et al., 2023). Since stigma is a public/societal problem, educational programs and public testimonies from individuals with experiences of AUD/SUD can combat public stigma, while support groups are recommended to address self-stigma (Corrigan & Rao, 2012; Livingston, Milne, Fang, & Amari, 2012). Although this knowledge stems from research on AUD/SUD directly, it is not farfetched to assume that it could help CSOs as well.

1.8 CHILDREN AFFECTED BY PARENTAL DRINKING

The adverse effects on children growing up in families where one or both parents have a problematic use of alcohol or other substances are well documented. The harms from parental drinking or substance use can stem from direct effects, such as incidents when the parent is intoxicated, or more indirect effects from parental neglect due to parent prioritizing substance use (Järkestig Berggren, 2016). Living with a parent with problematic alcohol or substance use is associated with being exposed to higher levels of violence, physical, verbal, or sexual abuse and poor or neglectful parenting, associations that exist in many different cultures (Laslett et al., 2020; Laslett et al., 2017; Syed, 2018; Velleman & Templeton, 2007, 2016). Further, substance use in one or more parents is associated with an unpredictable psychological environment for the children, for example due to parents responding differently to similar situations, leading to fear and uncertainty in the children, which are risk factors for children's impaired mental health (Alexanderson & Näsman, 2017; Park & Schepp, 2015).

Children exposed to parental problematic drinking or alcohol use disorder (AUD) are more likely to have early-onset and heavier drinking/substance use, develop own AUD/SUD, and have a higher prevalence of other psychiatric diagnoses, such as depression and anxiety - both in adolescence and adulthood, (e.g. Holst, Tolstrup, Sørensen, Pisinger, & Becker, 2019; Jääskeläinen, Holmila, Notkola, & Raitasalo, 2016; McGovern et al., 2023; Mellentin et al., 2016; Park & Schepp, 2015; Velleman & Templeton, 2007). Further, children of parents with AUD have been found to have a three-fold increased risk of early death due to suicide, accidents, or violence, compared to the general population (Hjern, 2014).

1.8.1 Prevalence of affected children

The prevalence of children who grow up with at least one parent with problematic drinking has in Swedish and international studies been suggested to be between 4-28 % (Grant, 2000; Haugland & Elgan, 2021; Manning, Best, Faulkner, & Titherington, 2009; Ramstedt, Raninen, Larm, & Livingston, 2022; Raninen, Elgán, Sundin, & Ramstedt, 2016). The large range in prevalence comes from differences in definitions of alcohol problems and methodologies used in the assessment, most often based on registers of treatment for AUD/SUD (Haugland & Elgan, 2021; Manning et al., 2009; Ramstedt et al., 2022). Estimations through registers have been argued as limited due to that mainly more severe cases of parental problematic drinking are detected, and hence leading to an

underestimation of children to less severely affected parents (Ramstedt, Raninen, Larm, & Livingston, 2023; Thor, Hemmingsson, Danielsson, & Landberg, 2022).

Recent estimates of affected children in Sweden have used a broader definition of problematic drinking in order to better capture the prevalence of affected children. A study from 2016 suggested that 13 % of fathers and 3 % of mothers have a problematic use of alcohol (Berg, Bäck, Vinnerljung, & Hjern, 2016). In a report from 2019, approximately 15 % of children between 0-17 years were estimated to be affected by problematic drinking of at least one parent during their upbringing (CAN, 2019).

Two recent studies resent results from a nationwide Swedish longitudinal survey. The first study reported that 13 % of children aged 15-16 years had experienced problematic drinking by at least one parent during adolescence (Ramstedt et al., 2022). The second study found that the risks of health, school performance, and social relationship issues increased with the severity of parental problem drinking, and that exposure to mild levels of parental problem drinking increased the risks compared to no exposure (Ramstedt et al., 2023). These studies support the claim that risks of problems associated to parental problematic drinking goes beyond the most severe cases of parental alcohol problems.

1.8.2 Protective factors and resilience for affected children

One recent systematic review that examines factors influencing resilience and vulnerability in affected children, covered a total of 39 studies. The findings from this review were categorized into four levels: individual, parental, familial, and social (Park & Schepp, 2015). At the individual level, factors such as high self-esteem, effective self-regulation, and a flexible and optimistic temperament were identified as protective factors. The parental level encompassed secure attachment, positive parent-child relationships, and positive and consistent parenting practices. At the familial level, having only one parent with substance misuse, high family cohesion, adaptability, and healthy interaction were deemed protective, along with the presence of other trustworthy family members and low levels of violence and conflicts. Lastly, the social level included factors such as social support and active participation in extracurricular activities (Park & Schepp, 2015).

Velleman & Templeton (2016) further specified individual protective factors such as internal locus of control, ability to express one's feelings, coping and problem-solving skills, knowledge and understanding of the parents' problems, self-monitoring skills, and a balance between looking after themselves and supporting their parents (Velleman & Templeton, 2016). Regarding parental substance problems specifically, the authors added that milder intensity and shorter duration of substance use are positive factors together with substance use occurring outside home, that drug activities and associates are kept away from children and lastly that parent(s) receive treatment (Velleman & Templeton, 2016).

1.9 SUPPORT PROGRAMS FOR AFFECTED CHILDREN

Many interventions aimed at reducing the impact of parental substance use upon children in families affected by substance use have been applied in different contexts such as social services, healthcare, mental health sector and voluntary sectors. Most prevalent are extensive programs for severely affected families (Järkestig Berggren, 2016; McGovern et al., 2021; Syed, 2018).

A UK-based scoping review of interventions aiming to reduce the impact of parental problematic alcohol use on children summarized 47 reviews and 313 primary studies, and identified four major designs of programs (see Figure 2). A majority (45 %) of the programs targeted the drinking parent(s) only (a), 33 % targeted both parents and children (b), ten percent directly targeted affected children (c), and seven percent targeted the CSO(s) directly (d). Parenting skills interventions, psychoeducational groups and family-based interventions (e.g. CRAFT) were among the interventions most often associated with reductions in parental problematic drinking and child-related harms (Syed, 2018).

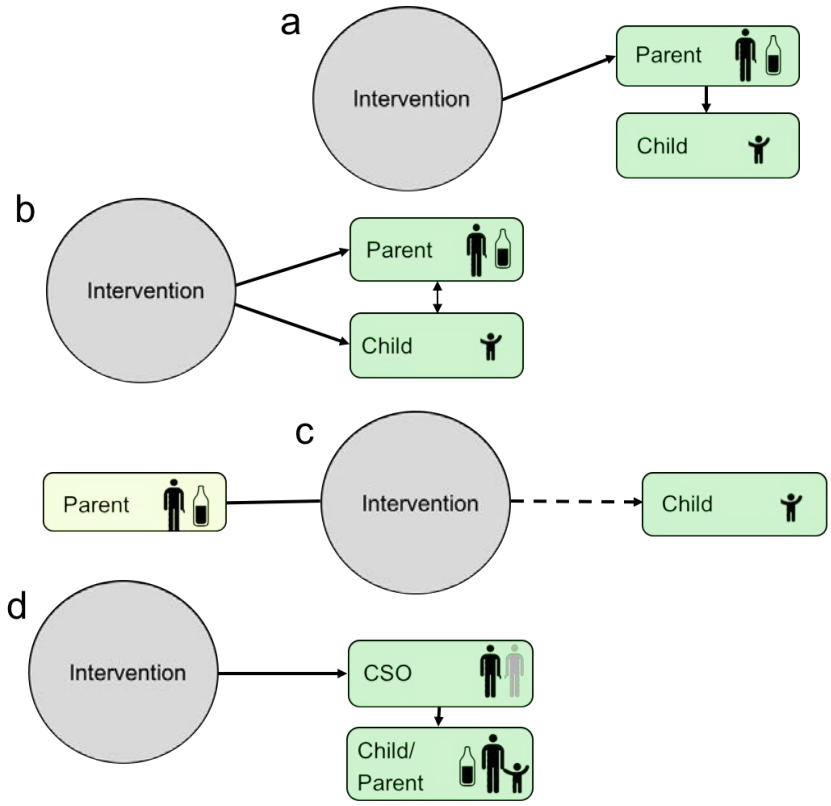

Figure 2. Illustration of different types of interventions targeting families, parents, children or CSOs affected by at least one parent with problematic alcohol- or substance use, with arrows showing how it is suggested to affect the parent/s and child. (a) Intervention directed at drinking parent(s) only; (b) family intervention directed both at parent(s) and child, (c) intervention directed at child only with the aim to decrease the impact that their parent's substance use has on them, and; (d) interventions directed at the CSO, mainly partner of the substance using co-parent.

McGovern et al (2021) reported results from 15 trials with interventions addressing the impact of parental SUD upon the family. The interventions mainly demonstrated effectiveness in improving family functioning and relationships, with some indications that parent training components as an add-on to SUD-treatment could improve parent skills. There were few trials aimed at parents/families that applied outcomes related to the children, but those who did reported decreases in child maltreatment and improvements in psychosocial adjustment compared to the control interventions (McGovern et al., 2021).

1.9.1 Interventions targeting the children directly

Interventions targeting children are often categorized as selective preventive interventions (meaning that children *at risk* due to parental substance use are targeted), and are mainly delivered in group form in schools or in community-based settings (Bröning et al., 2012; Järkestig Berggren, 2016; Syed, 2018). The interventions provide education about substance use, coping strategies, and a safe environment for sharing experiences (Bröning et al., 2012; Bröning et al., 2019; Syed, 2018). Reviews highlight difficulties summarizing these interventions due to variations in populations, outcomes, settings, and program content (Bröning et al., 2012; Järkestig Berggren, 2016; Syed, 2018). Tentative conclusions suggest that interventions like Stress Management and Alcohol Awareness Program (SMAAP) (Short et al., 1995) or TRAMPOLINE (Bröning et al., 2019) improve program knowledge, family relations, and child self-efficacy with low to moderate effect sizes, however often failing to demonstrate superiority over control or wait-list conditions (Bröning et al., 2012; Bröning et al., 2019; Järkestig Berggren, 2016).

In Sweden, the most commonly applied support program for affected children is Ersta Vändpunktens children's program (Socialstyrelsen, 2019), adapted from Children are People Too (CAP) (Lerner R. & Hawthorne, 1985). The program consists of 8-15 sessions providing information and group discussions with the aim to strengthen children's self-worth, competencies, and coping skills (Lerner R. & Hawthorne, 1985). A Swedish study of 300 children in Ersta Vändpunktens groups reported improvements in mental health, life satisfaction, and hopefulness, but lacked a control group (Skerfving, Johansson, & Elgán, 2014). No controlled study on CAP or Ersta Vändpunkten exist and further research is needed to assess the program's effectiveness (SBU, 2020; Socialstyrelsen, 2019).

In essence, the overall impact of interventions for affected children remain uncertain due to methodological weaknesses, limited sample sizes and large variation of scientific approaches. Another challenge is to attract affected children to seek support. Swedish estimates show that only ~2 % of the affected children receive any support intervention, mainly due to difficulty in identifying the children, but also due to parents being unwilling to disclose their substance use, and that the children find the offered support as unappealing (Elgán, 2015; Skerfving et al., 2014). New approaches to address these children are warranted, either directly or via a non-substance using parent.

1.10 PARENTING INTERVENTIONS

As previously mentioned, the relationship with the non-using parent plays a crucial role in promoting resilience among children (Park & Schepp, 2015; Velleman & Templeton, 2007, 2016). Parental strategies and support have significant impacts on the developmental trajectories of children, and parenting skills interventions in affected families are promising as a mean to improve the family environment for the affected children (McGovern et al., 2021; Syed, 2018). Hence, it is feasible to take departure in parenting interventions for potential strategies to use in interventions aimed at families affected by substance use.

Most behavioral parenting interventions were initially developed as treatments for disruptive child behaviors. With time, the programs have more often been used in prevention settings, classified into three different levels: *universal, selective and indicated* (Leijten et al., 2019; Salari & Enebrink, 2018). Universal parenting interventions are designed and offered to all parents in the community, promoting general positive parental behaviors. Selective programs are offered to groups with a common risk factor, while indicated programs are offered to parents of children with identified problems (Salari & Enebrink, 2018; Ulfsdotter, Enebrink, & Lindberg, 2014).

Parenting interventions are most often based in operant learning theory and social learning theory (Bandura, 1977b). Social learning theory (SLT) highlights the social and cognitive aspects of learning, describing how individuals acquire new behaviors, skills, and attitudes by watching and imitating role models. Parenting interventions thus emphasize the parent as a role model for the child, but also include components such as reinforcement of positive behaviors, elimination of reinforcement for negative behaviors, establishment and evaluation of consistent rules and boundaries, communication skills, and conflict prevention and management (Forehand, Jones, & Parent, 2013; Kjøbli et al., 2023; Leijten et al., 2019; Spencer, Topham, & King, 2020).

Several meta-analyses and review studies have examined the effects of selective and indicated parenting interventions, showing general improvements in disruptive child behaviors and short-term enhancements in parental levels of stress, depression, anxiety, anger, confidence (self-efficacy), and satisfaction with partner relationships (Barlow, Smailagic, Huband, Roloff, & Bennett, 2012; Leijten et al., 2019; Litschge, 2010; Lundahl, 2005). Universal interventions have shown small effect sizes on average, which may, in part, come from low prevalence rates of specific problematic behaviors in the general child population, leaving little room for improvement (Leijten et al., 2019; Salari & Enebrink, 2018). Parenting interventions have shown good cost-effectiveness, especially regarding the prevention of child externalizing and internalizing behaviors (Sampaio, Nystrand, Feldman, & Mihalopoulos, 2022; Ulfsdotter, Lindberg, & Månsdotter, 2015).

1.10.1 Parental self-efficacy

An underlying assumption in many parenting interventions is that *parental self-efficacy* (PSE) (sometimes labeled “parenting self-esteem”) will increase if parents are provided

with strategies to handle parenting practices successfully and to influence their children in healthy directions (Jones & Prinz, 2005). PSE is associated with promotive parenting practices, meaning positive approaches by parents to foster their children's skills, talents and interests, and prevent negative behaviors or adjustment issues (Ardelt & Eccles, 2001). PSE is regularly included as outcomes in studies on parenting training programs (Ulfsdotter et al., 2014). Decades of research have established a relationship between PSE and healthy functioning such as parental mental health, parent-child relationship, child psychological functioning and child externalizing behaviors (Albanese, Russo, & Geller, 2019; Jones & Prinz, 2005; Wittkowski, Garrett, Calam, & Weisberg, 2017).

A vast majority of the studies on PSE have utilized cross-sectional designs, which limit the possibilities to investigate the directionality of the relationships between PSE and key outcomes (Albanese et al., 2019). Results from one of few longitudinal studies suggested that level of PSE was more closely associated with promotive parenting practices in parents of younger children/early adolescents, but as the children grew older, the association was stronger between adolescent behaviors and PSE (Glatz & Buchanan, 2015). The results hence propose that the concept of PSE alters with time, with a larger impact from the adolescents as the children grows older.

1.11 INTERNET-BASED INTERVENTIONS

In Sweden, approximately 95 % of the population use the internet on a daily basis, and over 50 % use the internet for digital health care services (Internetstiftelsen, 2022). Interventions delivered online have many advantages, e.g. accessibility, possible anonymity, easy distribution etc. Interventions targeting alcohol problems have been shown to attract participants otherwise treatment reluctant due to stigma and shame (White, 2010), which appear to be true also for CSOs who are often afraid to reveal alcohol- or substance use problems in the family to authorities (Bröning et al., 2012; McCann & Lubman, 2018a; Osilla et al., 2018).

Over the past two decades, internet-delivered cognitive behavioral therapy (ICBT) has been increasingly recognized for its efficacy in treating various psychological and somatic conditions (Carlbring, Andersson, Cuijpers, Riper, & Hedman-Lagerlof, 2018). ICBT has consistently demonstrated superiority over non-active control conditions or treatment as usual (TAU) (Andersson, Titov, Dear, Rozental, & Carlbring, 2019) and in general, ICBT has proven similar treatment effects as face-to-face interventions (Hedman-Lagerlöf et al., 2023). In the field of addiction, internet interventions have shown efficacy in reducing alcohol consumption (Riper H., 2018), and a Swedish study found ICBT to be equally effective as face-to-face therapy for alcohol use disorder (Johansson et al., 2020).

Regarding internet-based support programs for CSOs, Rychtarik et al (2015) found that therapist-delivered internet-administered Coping Skills Training (iCST) improved coping skills, depression symptoms, and situational anger compared to a wait-list control (Rychtarik et al., 2015). Eék et al. (2020) evaluated an adapted version of CRAFT

(iCRAFT), which resulted in a higher number of relatives initiating treatment compared to wait-list, but the result was just above established levels of statistical significance. iCRAFT showed short-term improvements in depressive symptoms, quality of life, and relational happiness (EÉk et al., 2020b).

1.11.1 Self-guided internet-based interventions

Self-guided interventions, categorized as low-intensity CBT, utilize self-help materials and require minimal input from mental health professionals (Shafran, Myles-Hooton, Bennett, & Öst, 2021). Low-intensity internet interventions target the general public and are automated, without therapist guidance. (Andersson et al., 2019; Gratzer & Khalid-Khan, 2016; Grist & Cavanagh, 2013). Numerous studies have demonstrated the effectiveness of self-guided ICBT in reducing anxiety and depression, often yielding outcomes comparable to face-to-face treatment (Carlbring et al., 2018). Recent trials demonstrated comparable outcomes between therapist-guided and self-guided ICBT in decreasing alcohol consumption and symptoms of AUD, both in the short term (Sundström et al., 2020) and after 24 months (Eék et al., 2023).

CRAFT in self-delivered format, mainly in the form of workbooks, has shown promising results in trials for CSOs of individuals with problematic drinking (Hellum et al., 2022; Manuel JK, 2012), but no trial evaluating online self-delivered CRAFT, or any other support program for CSOs of relatives with a problematic alcohol- or substance use exist.

1.11.2 Internet-based parenting interventions

Four meta-analyses on internet-based parenting interventions reported significant improvements in child externalizing behaviors (also when self-delivered), parental confidence and mental health issues compared to waitlist or no treatment conditions (Baumel, Pawar, Kane, & Correll, 2016; Bausback & Bunge, 2021; Florean, Dobrean, Păsărelu, Georgescu, & Milea, 2020; Thongseiratch, Leijten, & Melendez-Torres, 2020). One review further showed a higher efficacy in reducing child externalizing behaviors in trials with parents of children with a mean age <7 years compared to trials with parents of children with a mean age >11 years (Baumel et al., 2016).

1.12 SUMMARY AND KNOWLEDGE GAPS

Previous studies on affected families have primarily focused on families in which one or more members have severe drinking problems, despite the fact that most of the harm caused by alcohol is associated with common and moderate drinking patterns. Therefore, there is a need for a better understanding of CSOs' experiences in the earlier stages of the relatives' problematic drinking, and in families affected by only one parent's drinking.

No approach combining components from CRAFT and parenting interventions has yet been investigated. Targeting non-drinking parents in families with problematic co-parent alcohol use could benefit CSOs, but also affected children. Delivering a program online with anonymity might attract CSOs otherwise hindered by stigma or reluctance to disclose family issues. A program with a dual-approach may modify parenting practices, reduce conflicts, improve CSO-child relationship, reduce co-parent drinking and encourage co-parent treatment seeking, potentially leading to enhanced child mental health. Since no previous trial exist, it is important to understand how the CSOs perceived the dual approach through qualitative investigation.

The burden coming from problematic alcohol- and substance use among young adults is substantial, yet few seek treatment. Interventions targeting parents of young adults with problematic substance use could narrow this treatment gap. However, no randomized controlled trial focusing on support programs for parents of young adults with problematic substance use exist. Non-randomized trials using CRAFT for parents of substance-using adolescents have shown promising results both regarding parental health related outcomes and for increasing treatment engagement among young adults. No prior study has investigated the experiences of CRAFT among parents of young adults with problematic substance use. Such a qualitative study is important in order to understand how the parents perceive CRAFT and if any adaptations to the program is to be recommended for this target population.

2 RESEARCH AIMS

The overall aim of this thesis was to investigate new ways of supporting CSOs of substance using individuals in new contexts, more specifically with the target population being both a CSO and a parent, applying programs based on CRAFT.

The specific aims of the studies were:

Study I: To investigate the efficacy of the online self-directed intervention Supportive PArenting and REinforcement (SPARE), combining CRAFT with a parenting intervention, vs psychoeducative material for CSOs sharing a child with a co-parent with problematic alcohol consumption regarding affected children's mental health.

Study II: To investigate reasons for seeking support as described by CSOs sharing a child with a co-parent with alcohol problems and to investigate how CSOs perceived SPARE.

Study III: To investigate the efficacy of CRAFT vs counselling for parents of treatment-refusing young adults with problematic substance use regarding treatment entry of the young adults.

Study IV: To explore the experiences of CRAFT among parents of young adults with problematic substance use.

3 THE EMPIRICAL STUDIES

3.1 STUDY I: AN ONLINE SELF-DIRECTED PROGRAM COMBINING COMMUNITY REINFORCEMENT APPROACH AND FAMILY TRAINING AND PARENTING TRAINING FOR CONCERNED SIGNIFICANT OTHERS SHARING A CHILD WITH A PERSON WITH PROBLEMATIC ALCOHOL CONSUMPTION: A RANDOMIZED CONTROLLED TRIAL

3.1.1 Methods

Aim: To investigate the efficacy of an online self-directed intervention combining components from Community Reinforcement and Family Training (CRAFT) with a parenting intervention for CSOs sharing a child with a co-parent with alcohol problems.

Design: A randomized controlled trial compared the efficacy of SPARE for CSOs sharing a child (3-11 years old) with a co-parent with alcohol problems (N=37), to an active control group (N=39) receiving written psychoeducative material (PM), allocation ratio 1:1. Assessment of outcomes was conducted at baseline, 3, 8 and 12 weeks.

Participants: CSOs were recruited from the community nationwide in Sweden through advertisement in social media and via two public and non-commercial websites. *Inclusion criteria:* a) at least 18 years of age; b) sharing a child (3-11 years old) with a co-parent with problematic drinking, defined as either a CSO-rated AUDIT-C score of > 4/5 (women/men) or fulfilling ≥ 2 ICD-10 dependence criteria; c) rating the shared child above the population mean of on any subscale (Range 0-1) or a total score of 4 on the parent rated Strengths and Difficulties Questionnaire (SDQ (Goodman, 1997)); d) a sufficient skill in written Swedish. *Exclusion criteria:* a) indications of own drinking problems, defined as an AUDIT-C score > 4/5 (women/men); b) use of illicit drugs >1 time per week during the last year; c) currently participating in support for CSOs of individuals with alcohol problems; d) mental health problems, defined as a DASS-21 score on all three subscales in the "Severe" range or 2/3 subscales in the "Extremely severe" range; e) under current threat of severe violence from co-parent.

Data collection: All data in the study were provided by the participating CSOs through a fully automated procedure on the study platform. CSOs provided informed consent digitally by checking a box before answering the screening questionnaires. In order to enter the study, CSOs created a personal, anonymous account with a unique username and password. CSOs then answered the screening questionnaires containing questions regarding CSOs themselves, the affected child and about the co-parent, which also served as the baseline measure. CSOs eligible for inclusion were informed that they would be allocated to one of two programs, were blinded to conditions and were automatically sent an email with a link to follow in order to start the intervention. The allocation to either SPARE or PM was performed upon clicking this link, and followed a computerized, fully concealed, block-randomization scheme (blocks of 20), re-shuffled prior to each draw, with no stratification.

Interventions: SPARE consisted of four sequential modules, all including components from both CRAFT and ABC. Each program module corresponded to approximately 10-15 pages of written material, including short films, exercises and some questions with free-text response. All four modules were divided into three different themes: a) Enhance CSOs own quality of life; b) Behavioral strategies for the CSOs regarding how to understand and handle the co-parents with alcohol problems; c) Parenting strategies. Themes a) and b) mainly comprised of elements from CRAFT and theme c) of elements from ABC. Exercises in all modules aimed at promoting behavior change and improving skills and were provided at the end of each module to be performed during the forthcoming week.

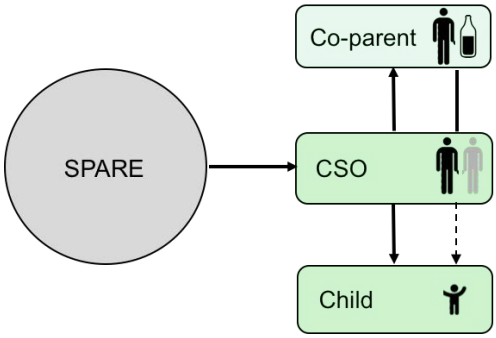

Figure 3. Illustration of how SPARE was expected to function by providing the CSOs with new strategies to handle co-parents' alcohol related behaviors and with promotive parenting practices to improve the children´s mental health.

The control condition (PM) contained four weekly distributed modules with themes; 1; Information about being a CSO to a relative with alcohol problems, 2; Information about problematic alcohol consumption and alcohol dependence, 3; Information about self-care for the CSO and how children can react to a parent being drunk, and 4; Information about where and how to seek further help if necessary. Each module corresponded to approximately 3-5 pages of written material and did not contain any exercises.

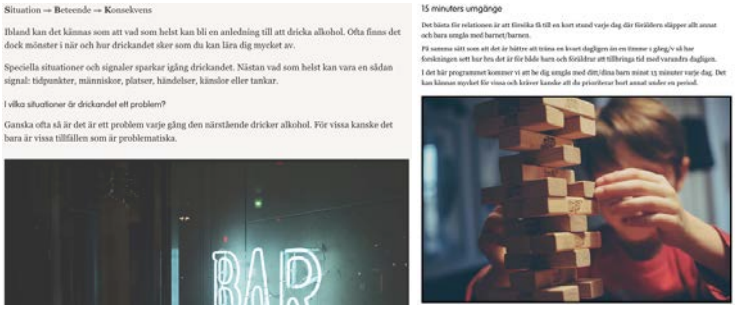

Figure 4. Examples of program content in SPARE.

Outcome measures: The primary outcome children's mental health was assessed by the parent-rated Strengths and Difficulties Questionnaire (SDQ) for children. The SDQ comprise 25 items on five subscales: emotional symptoms, peer relationship problems, conduct problems, hyperactive/ inattention and prosocial behaviors. The total score of the SDQ equals the combined score of the four subscales measuring problematic behaviors and was the primary outcome measure of the study.

Psychological health for CSOs was measured using the 21 item Depression, Anxiety and Stress Scale (DASS-21) (Alfonsson, Wallin, & Maathz, 2017; Lovibond & Lovibond, 1995). Alcohol consumption was assessed by the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) (Bush, 1998). Co-parent alcohol dependence was measured by a questionnaire comprising the six diagnostic criteria for alcohol dependence according to ICD-10 (WHO, 2010) was used. Parental self-efficacy (PSE) was measured using a shortened version of a 48-item questionnaire developed by (Ulfsdotter et al., 2014), with each of the 10 items rated on an 11-point Likert-scale (0-10), resulting in a total score between 0-100 where a higher score indicates a higher level of PSE. CSO-perceived self-efficacy in handling effects of co-parent alcohol consumption (PSE-A) was measured through a novel, tailored questionnaire developed by the research group, based on the PSE-scale developed by (Ulfsdotter et al, 2014). PSE-A consisted of six items, resulting in a total score between 0-60 with higher scores indicating a higher level of PSE-A. Relational warmth and conflicts between CSO and child were measured using the Adult-Child Relationship Scale (ACRS) (Trentacosta et al., 2011). To assess further support seeking for either the CSO, the child or treatment for the co-parent, CSOs stated number of contacts made with treatment providers since the previous assessment point.

Sample size: The study was designed to detect a minimum between-group effect size of 0.4 as defined by Cohen with a t-test power of 80 % (two-sided, p=0.05). The sample size was initially determined to 300 participants.

Data analyses: Outcome modeling was performed according to the intention-to-treat principle (ITT), using linear mixed effect models with random intercepts. By modelling data at both group (fixed) and individual (random) levels, mixed models are well-suited for data from repeated observations (modeling clustering of data at an individual level) (Hesser, 2015). Maximum likelihood estimation was used to handle missing data (Enders, 2011). A factorial time variable (covering all timepoints, with baseline as reference) was used, with omnibus effects reported. In order to investigate changes within the sample as a whole and within the two separate arms, post hoc analysis of differences in means at the different time points were performed using Bonferroni adjusted t-tests.

3.1.2 Results

The inclusion pace was much lower than expected, and enrollment was terminated when a pre-set cut-off date was reached, at which point 76 CSOs had been included (see Table 1 for further baseline characteristics). Notably, a majority of interested CSOs were excluded

at baseline assessment, mainly due experiences of co-parent violence (Siljeholm, Lindner, Johansson, & Hammarberg, 2022).

Table 1. Baseline characteristics for CSOs and co-parents

CSO	**SPARE (N=37)**	**PM (N=39)**
Sociodemographic characteristics		
Gender, female, N (%)	36 (97.3)	37 (94.9)
Age CSO, years, M (Range)	39 (28-50)	40.5 (30-52)
Age child, years, M (SD)	7.58 (2.26)	7.73 (2.42)
Cohabitation, N (%)		
Living with partner and child	27 (73)	37 (94.9)
Living alone with child	6 (16.2)	1 (2.6)
Other (changing circumstances)	4 (10.8)	1 (2.6)
Custody of the child, N (%)		
CSO joint custody with co-parent	31 (83.8)	38 (97.4)
Other (CSO sole custody, joint custody with another person or co-parent joint custody not with CSO)	6 (16.2)	1 (2.6)
Level of education, N (%)		
University or college	28 (75.7)	29 (74.4)
Upper secondary school/training school or equivalent	6 (16.2)	9 (23.1)
Other (primary school, folk school, or other)	3 (8.1)	1 (2.6)
Residence, N (%)		
Single-family home or row house	20 (54.0)	27 (69.2)
Condominium	8 (21.6)	4 (10.3)
Rental apartment	7 (18.9)	8 (20.5)
Sublease or other	2 (5.5)	0 (0)
Work characteristics, N (%)		
Employed or self-employed	36 (97.3)	35 (89.7)
Other (student, unemployed, sickness/activity pay)	1 (2.7)	4 (10.3)
Relationship to co-parent, n (%)		
Current partner	27 (73.0)	36 (92.3)
Ex-partner	8 (21.6)	3 (7.7)
Other	2 (5.4)	0 (0)
Co-parent		
Severity of alcohol problems, M (SD)		
Audit C-score	8.49 (2.01)	8.36 (1.71)
ICD 10 criteria for alcohol dependence	4.38 (1.52)	4.03 (1.49)

3.1.2.1 Primary outcome

Participants in the SPARE condition reported a decrease in SDQ-score for their children from 12.3 to 10.7 between baseline and the 12-weeks follow-up, while those in the PM condition reported an increase from 11.5 to 12.6 (Table 2). However, the statistical analysis revealed no significant difference in change over time between the two treatment conditions

(Table 3). Additionally, the post hoc Bonferroni adjusted t-tests showed no significant mean score changes within either group from baseline to 12 weeks follow-up (SPARE: difference=1.02, t=1.28, p=1.00; PM: difference=−1.22, t=−1.54, p=1.00) (not displayed).

Table 2. Observed primary and secondary outcomes at the different timepoints.

Outcome	Condition	Baseline (N=76)	Mid-intervention (3 weeks) (N=28–37) [a]	Post-intervention (8 weeks) (N=44–48) [a]	Follow-up 12 weeks (N=32–38) [a]
SDQ score, M (SD)	SPARE	12.3 (6.75)	11.0 (4.71)	10.4 (4.89)	10.7 (6.26)
	PM	11.5 (4.14)	11.6 (5.23)	11.8 (4.80)	12.6 (5.98)
SDQ internalizing behavior, M (SD)	SPARE	5.57 (3.36)	4.79 (3.24)	4.53 (2.46)	4.63 (3.46)
	PM	4.77 (2.92)	4.71 (2.79)	5.04 (3.08)	5.75 (3.45)
SDQ externalizing behavior, M (SD)	SPARE	6.73 (4.21)	6.21 (3.33)	5.84 (2.89)	6.06 (2.95)
	PM	6.72 (3.24)	6.93 (4.16)	6.80 (3.74)	6.88 (3.65)
ACRS Warmth, M (SD)	SPARE	16.9 (2.59)	16.6 (1.91)	17.0 (1.97)	17.2 (1.83)
	PM	17.1 (1.91)	15.8 (2.51)	16.5 (2.43)	16.4 (2.60)
ACRS Conflict, M (SD)	SPARE	10.2 (4.52)	9.57 (5.46)	9.26 (4.43)	7.94 (4.06)
	PM	9.00 (4.84)	8.69 (4.82)	9.00 (5.45)	8.62 (6.33)
PSE, M (SD)	SPARE	72.6 (10.5)	69.9 (8.88)	73.2 (10.2)	71.8 (10.2)
	PM	72.6 (10.5)	67.8 (11.8)	74.0 (9.76)	72.3 (12.0)
PSE-A, M (SD)	SPARE	31.9 (12.7)	33.1 (11.5)	36.6 (11.0)	33.4 (12.4)
	PM	29.8 (13.1)	39.4 (14.6)	34.9 (12.2)	36.6 (14.2)
CSO-score DASS Depression, M (SD)	SPARE	8.70 (8.46)	7.73 (6.96)	11.1 (8.88)	10.0 (7.60)
	PM	12.5 (7.74)	11.5 (9.91)	10.6 (8.00)	13.9 (10.6)
CSO-score DASS Anxiety, M (SD)	SPARE	4.32 (4.04)	5.20 (5.94)	6.42 (6.41)	6.30 (7.09)
	PM	6.51 (5.94)	6.18 (7.03)	5.38 (5.76)	9.22 (8.63)
CSO-score DASS Stress, M (SD)	SPARE	16.9 (7.83)	19.6 (9.36)	18.6 (9.48)	15.9 (9.05)
	PM	18.3 (6.25)	19.0 (9.62)	16.6 (8.02)	18.8 (10.1)
Co-parent AUDIT-C score, M (SD)	SPARE	8.49 (2.01)	6.93 (4.27)	7.26 (3.12)	6.65 (3.03)
	PM	8.36 (1.71)	7.18 (2.86)	7.45 (3.05)	7.56 (2.89)
Co-parent ICD 10 criteria, M (SD)	SPARE	4.38 (1.52)	3.53 (1.88)	3.26 (2.08)	3.30 (2.08)
	PM	4.03 (1.50)	4.05 (1.50)	3.52 (1.70)	3.56 (2.01)
Help seeking Child (accumulated), N (%)[b]	SPARE	0 (0)	0 (0)	0 (0)	0 (0)
	PM	0 (0)	0 (0)	1 (1.3)	1 (1.3)
Help seeking CSO (accumulated), N (%)[b]	SPARE	0 (0)	2 (2.6)	4 (5.2)	8 (10.5)
	PM	0 (0)	3 (3.9)	9 (11.8)	13 (17.1)
Help seeking Co-parent (accumulated), N (%)[b]	SPARE	5 (6.6)	5 (6.6)	6 (7.9)	7 (9.2)
	PM	9 (11.8)	10 (13.2)	12 (15.8)	13 (17.1)

[a] Note that the range of *n* varies. The questionnaires were divided into two segments and some CSOs missed the second segment of questionnaires in the follow-ups.

Table 3 Results from the ITT mixed model analysis of primary and secondary outcomes.

Outcome	**Fixed effect Omnibus test**		
	Group	**Time**	**Group x Time**
SDQ total score	F=0.041, df=1 p=0.841	F=0.60, df=3 p=0.617	F=1.56, df=3 p=0.204
SDQ internalizing behavior	F=0.098, df=1 p=0.755	F=0.320, df=3 p=0.811	F=2.065, df=3 p=0.110
SDQ externalizing behavior	F=0.330, df=1 p=0.567	F=0.851, df=3 p=0.469	F=0.586, df=3 p=0.625
ACRS Warmth	F=0.306, df=1 p=0.582	F=2.505, df=3 p=0.064	F=1.023, df=3 p=0.386
ACRS Conflict	F=0.094, df=1 p=0.760	F=1.988, df=3 p=0.121	F=2.391, df=3 p=0.073
PSE	F=0.004, df=1 p=0.949	F=2.492, df=3 p=0.065	F=1.129, df=3 p=0.943
PSE-A	F=3.09e-4, df=1 p=0.986	F=5.72, df=3 p=0.001	F=1.66, df=3 p=0.181
DASS Depression	F=2.318, df=1 p=0.132	F=0.496, df=3 p=0.686	F=1.480, df=3 p=0.223
DASS Anxiety	F=1.66, df=1 p=0.201	F=2.75, df=3 p=0.045	F=1.68, df=3 p=0.174
DASS Stress	F=0.296, df=1 p=0.588	F=0.365, df=3 p=0.778	F=0.964, df=3 p=0.412
AUDIT-C co-parent	F=0.318, df=1 p=0.574	F=6.275, df=3 p=<0.001	F=0.511, df=3 p=0.675
ICD-10 criteria co-parent	F=0.002, df=1 p=0.965	F=4.79, df=3 p=0.003	F=0.572, df=3 p=0.634
Help seeking child	chi^2=0.746, df=1, p=0.388	chi^2=8.003, df=3, p=0.046	chi^2=2.533, df=3, p=0.469
Help seeking CSO	chi^2=0.0035, df=1, p=0.953	chi^2=24.17, df=3, p=<0.001	chi^2=0.042, df=3, p=0.998
Help seeking co-parent	chi^2=0.466, df=1, p=0.495	chi^2=1.920, df=3, p=0.589	chi^2=0.527, df=3, p=0.913

Group represents the effect of treatment condition on the primary and secondary outcomes, Time represents the effect of time on the changes in estimates during the follow-up period regardless of treatment condition. Finally, Group x Time is the interaction effect of group over time, i.e. indicating if the change in estimated results differs significantly over time between the two treatment conditions.
[b] Because the measure is accumulated, reported percentages are relative to baseline (N=76).

3.1.2.2 Secondary outcomes

No significant effects between the conditions were found in the secondary outcomes during the follow-up period. The sample as a whole reported a significant reduction in co-parent alcohol consumption (AUDIT-C), severity of alcohol dependence (ICD 10 criteria) and improvements in PSE-A (Table 3). A post hoc test showed that the mean ACRS conflict score in the SPARE-condition decreased between baseline and 12 weeks follow-up (difference = 2.82, t = 3.40, p = 0.027) (not displayed), whereas the mean in PM did not (difference = -0.33, t = -0.45, p = 1.000) (not displayed).

3.2 STUDY II: A SHIFT IN FOCUS: MOTHERS' DESCRIPTIONS OF SHARING A CHILD WITH A CO-PARENT WITH UNHEALTHY ALCOHOL USE AFTER PARTICIPATING IN A SUPPORT PROGRAM

3.2.1 Methods

Aim: To explore the reasons why CSOs, who share a child with a co-parent with a drinking problem, seek support and to examine their perceptions of SPARE.

Design: A qualitative design which employed interviews with CSOs who had completed at least two of the four modules in SPARE (Study I).

Participants: After completing the 12-week follow-up assessment in study I, CSOs were approached via e-mail. Thirteen of 42 CSOs expressed interest to participate and were interviewed. All 13 CSOs were women who shared at least one biological child aged 3–11 years with a male co-parent.

Data collection: All interviews were conducted by authors OS and VE between May 2019 – April 2020, either face-to-face, via video conference or by telephone, were recorded and subsequently transcribed verbatim. The first two interviews were performed by both authors together, while the remaining 11 were conducted by either of the two. The interviews lasted for 45-60 minutes. A semi-structured interview guide with open-ended questions was used. The interview started with the broad question "Tell me about yourself and your family and why you applied to the study". Examples of central questions were: "How has the program affected you as a parent?" and "In what way has the program affected your understanding of the co-parent's relationship to alcohol?". The CSOs were also asked questions about how and when they used the SPARE-program, what they hoped to gain from entering the study and if they felt they needed additional support after the program. For a full description, see (Siljeholm, 2023c)

Data-analyses: The analyses were made with an inductive approach to code the data material without a pre-defined code system or analytical framework and were performed using conventional qualitative content analysis as described by Hsieh & Shannon (Hsieh & Shannon, 2005). Since the aim of this study was to examine two specific differing topics (Reasons for seeking support and Perceived effects of the program), the interviews were divided into two domains. First, the transcribed interviews were read several times from beginning to end, to get a sense of the text as a whole. Next, the texts were read more thoroughly to identify codes that were either present in the text, or that consisted of a few words that encapsulated the meaning of a certain sentence. Within each domain, the relationships between the codes were then investigated, and suggested categories and subcategories were formulated in discussion between the authors.

3.2.2 Results

The results were divided by the two domains Reasons for seeking support and Perceived effects of the program with different categories and subcategories in each area (table 4).

Table 4. Domains, categories and subcategories.

DOMAINS	REASONS FOR SEEKING SUPPORT	PERCEIVED EFFECTS OF THE PROGRAM
CATEGORIES AND SUB-CATEGORIES	Emotional validation and support	Acknowledgement and relief
	Coping with co-parent drinking - Escalation of drinking and alcohol-related consequences - Wanting new coping strategies in relation to the co-parent	Change in my own behavior - Interaction with the children - Taking care of myself - Coping with the co-parent
	Worrying about the children	Missing in the program
	Perceptions of available support for CSOs	

3.2.2.1 Reasons for seeking support

The domain Reasons for seeking support was divided into four categories with two subcategories (table 4). The main reasons for entering the program included a wish for validation/emotional support and to acquire strategies to cope with unwanted co-parent behaviors, as well as dissatisfaction with existing support options for CSOs. Participants also appreciated the possibility to be anonymous and to use the program when it suited them since this was in clear contrast to how they perceived existing support options.

Regarding coping with co-parent drinking, the CSOs described a continuous escalation over time regarding consequences related to alcohol consumption, which had led to a point where it was impossible to leave unmanaged. Most CSOs were struggling with mixed feelings about their co-parent since he, while sober, was a fantastic parent, partner and person in general, but that drinking made him unreliable, dull, absent, selfish and - in some cases - mean. They all had experiences of arguing and fighting with the co-parent, which in some instances could make things better for a while. Eventually, however, the co-parent always returned to previous behaviors and the CSOs expressed that they needed new coping strategies for how to handle this situation more long-term.

Most of the CSOs did not describe any explicit events where the co-parent's behavior was perceived as especially harmful towards the children, such as physical violence. There were, however, several descriptions of absent co-parents, low-intense parental neglect from the co-parent, and exposure to co-parent drinking. A few CSOs stated that a main reason for staying in the relationship was worrying about how the children would be treated if the parents separated and did not want the children to live alone with the co-parent every other week. In general, however, most CSOs expressed more of a general sense of worry that their children might be affected further down the line, or that they did not know how the co-parent's consumption affected the children.

3.2.2.2 Perceived effects of the program

The domain Perceived effects of the program was divided into three categories and three subcategories (table 4). Practically all of the CSOs expressed how one of the most apparent effects of the program was a sense of relief after being acknowledged that the circumstances they were living under were not normal. Many CSOs had doubted themselves and their perception of the co-parent's drinking as causing stress and strain both on themselves and their children. Many co-parents had also told the CSOs that they exaggerated the negative effects of their consumption. SPARE helped them to realize that they were entitled of being angry and stressed, and that they were justified to receive support. This entitlement was perceived as empowering which helped them to question the co-parent, to talk more openly to the children and to make room for activities of their own. Hence, acknowledgement played a crucial role in enabling the CSOs to start making changes in their own behaviors by interacting more with the children, taking better care of themselves and coping differently with the co-parent.

Shifting focus from the co-parent towards the children was seen as one of the most positive and rewarding experiences of the program, both for the CSOs themselves, but also for the children. Several CSOs reported having more fun with the children, talking more to them and experiencing less conflicts. An increased engagement in own positive activities (especially physical activity) was mentioned as helpful in regaining energy, leading the CSOs to feel calmer and better prepared for handling both the daily chores and interaction with the children, but also potential situations arising from the co-parent consumption. Several CSOs mentioned how they felt better at maintaining clearer boundaries for themselves, meaning that they no longer adapted as much to co-parent alcohol related behaviors. This shift in CSOs' behavior resulted for example in co-parents having to handle negative consequences of their alcohol consumption. The most prominent behavior change appeared to be a shift from complaining on the co-parent's shortcomings towards using a more positive tone.

The most common perception of what was missing in the program amongst the CSOs was interaction with a living person, since meeting a therapist would have allowed for more interaction and tailored guidance. A majority of the CSOs said that they would like additional support after completing the program, but the feeling was a lot less urgent than when they entered the study. Some CSOs had already sought further support and said that participation in the study was an important first step in the process.

3.3 STUDY III: COMMUNITY REINFORCEMENT AND FAMILY TRAINING VERSUS COUNSELLING FOR PARENTS OF TREATMENT REFUSING YOUNG ADULTS WITH HAZARDOUS SUBSTANCE USE: A RANDOMIZED CONTROLLED TRIAL.

3.3.1 Methods

Aim: To compare CRAFT to manualized counselling for parents of young adults with problematic substance use who refuse to enter treatment.

Design: A randomized controlled trial compared the efficacy of CRAFT for parents of young adults (18-24 years old) (N=58), to an active control group (N=55) receiving manual-based counselling sessions. Parents were allocated to either condition for a period of 14 weeks. The design included a baseline measure and follow-up at 6, 12 and 24 weeks.

Setting: The trial was conducted at two outpatient clinics for adolescents and young adults within the Stockholm Centre for Dependency Disorders and Stockholm Municipality, Stockholm, Sweden, but subsequently via videoconference due to Covid-19.

Participants: Participants were recruited between October 2018 and May 2021 via advertisement in social media and through the clinics. From March 2020 to end of study, all study activities (including treatment sessions) were conducted via videoconference, enabling recruitment of parents from all over Sweden.

Inclusion criteria: a) Parent (or corresponding relationship) to a treatment refusing young adult with problematic substance use defined as a parent rated score >2 on the questionnaire Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) (Knight et al., 1999); b) contact (face-to-face or telephone) with young adult at least 50 % of days per week; c) declaring a strong desire for young adult to enter treatment. *Exclusion criteria:* a) fulfilment of any SUD (except nicotine) according to DSM-5 criteria; b) frequent use of illicit substances; c) significant psychological or cognitive impairments; d) participation in support intervention for parents the previous three months; e) young adult in treatment for substance use the previous 30 days; f) young adult fulfilling criteria for severe psychiatric conditions such as psychotic disorder; g) young adult behaved violently towards parent during the last year.

Initially, criteria included parents of adolescents between 15-19 y/o. However, Swedish law requires healthcare staff to report to social services when receiving information of an adolescent (under 18 y/o) who use illicit drugs. In order to avoid possible confounding effects from interventions from the social services, the inclusion criteria were adjusted for the young adult to be between 18-24 y/o when 21 participants had been included. Seven participants who were parents of young adults under age 18 had been included at the time. All of these were kept in the analyses since no one had received any support interventions from the social services.

Data collection: All data in the study, including data regarding the young adult, were provided by the participating parents. A telephone screening covered the most important eligibility criteria, and if no exclusion criteria were fulfilled, a more extensive face-to-face

interview was performed. Eligible participants filled out baseline questionnaires and were allocated to treatment condition at the end of the face-to-face interview. The first 52 participants were assessed for eligibility, and had all sessions delivered, face-to-face, and for the remaining 61 participants, eligibility assessment and treatment sessions were delivered via video conference. Participants assessed via video were sent the baseline questionnaires via regular mail together with a pre-paid and addressed response envelope. All 6- and 12- week follow up questionnaires were collected via regular mail. Before March 2020, all participants came to the clinic for a face-to-face follow up with a study coordinator at 24 weeks, but all assessments performed later than that was conducted via videoconference and questionnaires were sent via regular mail.

Interventions: CRAFT comprised of eight individual sessions á 45-60 minutes with themes in accordance with the CRAFT manual (Smith & Meyers, 2004) adapted for parents of young adults through appropriate case descriptions and facts about relevant substances. Between each session the participants received an exercise from the original program manual (Smith & Meyers, 2004) aimed at promoting behavior change and improving skills. The themes were: 1) Introduction and motivational enhancement for parents to engage in the CRAFT program; 2) Functional analysis of young adult's substance use; 3) Positive communication skills; 4) How to encourage sobriety and positive reinforcement; 5) Parent's own well-being; 6) Strategies for coping with young adult's substance use; 7) Problem-solving and young adult treatment engagement; 8) Summary and maintenance of results.

By providing behavioral strategies to the parents, CRAFT was hypothesized to increase young adult's treatment entry, while simultaneously improving parental mental health, young adult's substance use and parent-young adult relationship (see Figure 5 for an illustration).

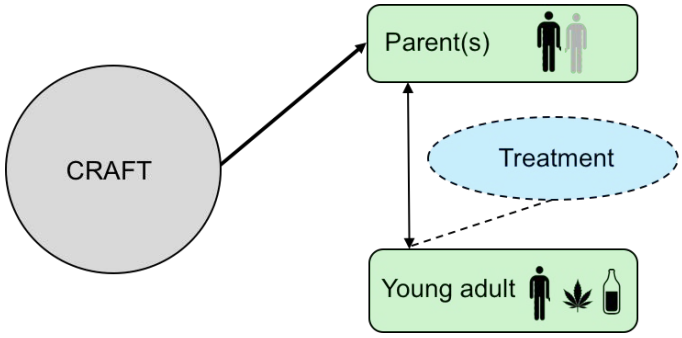

Figure 5. Illustration of how CRAFT for parents of young adults was expected to function.

The manualized counseling program comprised five individual 45 min sessions and one optional group psychoeducation session. The first four sessions comprised the following themes: 1) Problem description, parent's concern and understanding of young adult's substance use; 2) Parents response to young adult substance use; 3) Mapping young adult's social network; and 4) Relational patterns in the family. The fifth session was a follow-up session four weeks after session four. No home assignments were included but could be

provided as per therapists´ suggestions. The 90-minute optional group psychoeducative session was provided by staff at the clinic and included information about drugs and the developing brain. Participants were other parents engaged in the study, but the group session was also open for parents of young adult patients with an ongoing treatment at the clinic. For further details on the interventions, see (Siljeholm, 2023b)

Outcome measures: The primary outcome measure was participants' reports on young adult treatment seeking for problematic substance use with the following pre-specified treatment alternatives: Region-, or municipality-based addiction treatment, support groups (e.g. Narcotics Anonymous), primary care, psychiatry, telephone support line, internet-based or other (free-text).

Young adult frequency of alcohol- and substance use one month prior to inclusion and to 24 weeks after inclusion, was assessed by a tailored version of TimeLine FollowBack (TLFB) (Sobell & Sobell, 1992). Parents registered "A" for days with alcohol consumption and "D" for days with drug use. Young adult severity of substance use was measured using the Drug Use Disorder Identification Test (DUDIT) (Berman, Bergman, Palmstierna, & Schlyter, 2005; Matuszka et al., 2014). Young adult alcohol consumption was assessed by the Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) (Bush, 1998; Källmén, Anne, Jayaram-Lindström, Hammarberg, & Tobias, 2019). To assess participants mental health and quality of life, the 21 item Depression, Anxiety and Stress Scale (DASS-21) (Alfonsson et al., 2017; Lovibond & Lovibond, 1995) was used together with Satisfaction With Life-Scale (SWLS) (Pavot & Diener, 2008; Pavot, Diener, Colvin, & Sandvik, 1991) and the EuroQoL-5D visual analogue scale (EQ5D-VAS) (Brooks, 1996; Greiner et al., 2003). Happiness with the relationship to the young adult was assessed using the Relationship Happiness Scale (RHS) (Azrin et al., 1973; Sisson & Azrin, 1986). Parental self-efficacy (PSE) was measured by a 48-item questionnaire developed by Ulfsdotter et al (Ulfsdotter et al., 2014). Satisfaction with treatment was measured at 12 weeks by the Client Satisfaction Questionnaire (CSQ-8) (Larsen, Attkisson, Hargreaves, & Nguyen, 1979).

Sample size: Based on available data from participating clinics, approximately 10 % of participants in the control condition were expected to report treatment seeking for their young adults. Previous studies on CRAFT in similar patient groups have been carried out in treatment contexts highly dissimilar from the present one, for example offering readily accessible treatment and monetary compensation for the adolescents (Waldron et al., 2007), which was not possible in our trial. Further, records from the clinics showed that approximately 40 % of patients did not show up to the first treatment visit, indicating that the younger population may be less inclined to take part in treatment than adults. Given these assumptions, 30 % of participants in CRAFT were estimated to report treatment engagement for their young adults. Using a two-sided test with a significance level of 5%, 62 participants in each group were needed to achieve 80 % statistical power. Assuming an attrition rate of 20 %, 78 participants per group were required. Permitting a block size of 10, 80 participants were expected to be included in each group.

Data analyses: Outcome modelling was performed according to intention to treat (ITT)-principles, using mixed effects models for all outcomes. Additional analyses applied chi-square tests, Mann-Whitney U-tests or t-tests. Per protocol (PP)-analyses were performed including CRAFT participants completing at least five of eight sessions and counseling participants completing at least three of five sessions.

3.3.2 Results

After recruiting 70 % of the target number of participants, an interim analysis on the primary outcome was performed by a statistician independent from the research team and blinded to conditions. The analysis revealed an almost identical proportion of treatment seeking young adults in both conditions, where after recruitment was decided to be terminated. For baseline characteristics, see table 5.

Table 5. Baseline demographic and clinical characteristics

Participants	**CRAFT n=58**	**Counselling n=55**
Gender, female, n (%)	53 (91%)	51 (93%)
Age (years), mean (SD)	50.9 (5.3)	51.9 (6.6)
Days spent with young adult past month, mean (SD)	24 (10.4)	22.3 (10.1)
Level of education, n (%)		
University or college	38 (65%)	37 (65%)
Source of income, n (%)		
Employed or self-employed	51 (88%)	50 (88%)
Depression Anxiety Stress Scale (DASS-21)	**Mean (SD)**	**Mean (SD)**
Depression	7.3 (8.4)	7.3 (7.4)
Anxiety	2.8 (5.3)	3.7 (5.3)
Stress	10.9 (8.3)	12.3 (8.5)
Young adults	**CRAFT**	**Counselling**
Gender, male, n (%)	48 (83%)	50 (88%)
Age (years), mean (SD)	19.8 (1.86)	20.2 (2.1)
Employment, n (%)		
Studies	21 (36%)	13 (24%)
Job	19 (33%)	21 (39%)
No employment	18 (31%)	20 (37%)
Primary problematic substance, n (%)		
Cannabis	32 (55,2%)	33 (60%)
Alcohol	6 (10.3%)	5 (9%)
Other (Cocaine, oipioid analgesics, amphetamines, benzodiazepines)	20 (34.5%)	17 (31%)
	Mean (SD)	**Mean (SD)**
Days with substance use past month	12.4 (12.8)	11.7 (10.8)
Days with alcohol use past month	6.45 (5.1)	9.2 (7.8)

3.3.2.1 Primary outcome

Participants in the CRAFT condition reported that 19 young adults (33 %) entered treatment up until the 24 weeks follow up, while participants in the counselling condition reported 17 cases (31 %) (figure 6), with no statistically significant difference between groups (χ^2 (1) = 0.0042, p=0.948) (table 6). Initiated treatment reported were: 19 cases to Region-based addiction treatment, ten cases to municipality-based addiction treatment, three cases to support groups, two cases to private addiction treatment, one case to primary care services and one case to internet-based treatment, and one without specification.

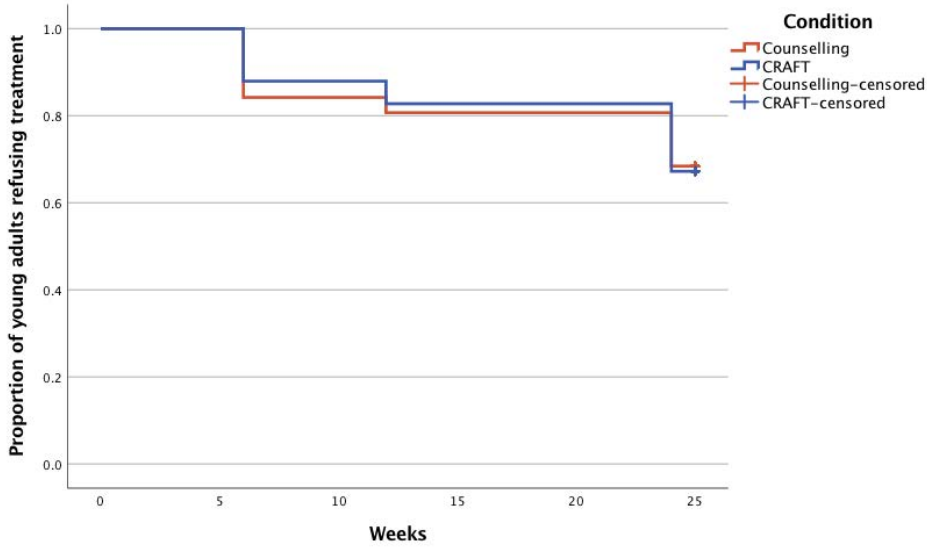

Figure 6. Treatment seeking among young adults presented by condition as a Kaplan-Meier curve with assessment points at 0 (baseline), 6, 12 and 24 weeks.

3.3.2.2 Secondary outcomes

Participants in the CRAFT condition reported a reduction in substance use by 49.6 % for the young adults after 24 weeks, while participants in counselling condition reported a 32.7 % reduction, with no statistically significant differences between groups (table 6). Regarding alcohol use, the decrease for CRAFT was 30 %, which was a larger reduction than for the counselling group (20.7 %) (table 6). The counselling condition showed within-group reductions concerning severity of substance use (DUDIT-score) and alcohol consumption (AUDIT-C score) (table 6), but no significant difference between conditions were found.

Table 6. Observed scores for primary outcome and predicted scores for secondary outcomes at baseline and 24 weeks, and between group's effects at 24 weeks.

	Baseline		24 weeks		Between group's effect at 24 weeks
Young adult					
	CRAFT (n=45-58)[a]	Counselling (n=49-55)	CRAFT (n=38-56)	Counselling (n=41-51)	Chi-square, (CI, p)[b]
Treatment entry (accumulated), n (%)[c]	0 (0)	0 (0)	19 (32.8)	17 (30.9)	χ^2 (1) = 0.0042, p=0.948)
	Mean (CI)	Mean (CI)	Mean (CI)	Mean (CI)	Incidence Rate Ratio CRAFT vs counselling, (CI, p)
Days with substance use previous month	12.5 (8.45; 18.5)	10.7 (7.2; 15.75)	6.3 (4.2; 9.5) ††	7.2 (4.8; 10.7) ††	0,88 (0.50; 1.55, p=0.665)
Days with alcohol use previous month	6.0 (4.5; 7.9)	8.2 (6.3; 10.8)	4.2 (3.1; 5.6) ††	6.5 (4.9; 8.6) †	0,64 (0.43; 0.96, p=0.030)
	Mean (CI)	Mean (CI)	Mean (CI)	Mean (CI)	Time x condition, (CI, p)
DUDIT	17.8 (15.2; 20.45)	17.6 (15.0; 20.3)	17.6 (14.95; 20.2)	15.15 (12.45; 17.85) †	2.43 (-1.34; 6.20, p=0.204)
AUDIT-C	5.6 (4.9; 6.2)	5.9 (5.3; 6.6)	5.4 (4.7; 6.1)	5.3 (4.66; 6.0) †	0.10 (-0.84; 1.05, p=0.832)
Parent					
DASS-21 depression	7.6 (5.3; 9.9)	7.2 (4.9; 9.5)	7.5 (5.15; 9.9)	7.2 (4.8; 9.6)	0.29 (-3.08; 3.65, p=0.867)
DASS-21 Anxiety	2.8 (1.2; 4.5)	3.7 (2.0; 5.3)	4.3 (2.6; 6.0)	4.4 (2.7; 6.2)	-0.14 (-2.57; 2.30, p=0.912)
DASS-21 Stress	11.2 (8.8; 13.5)	12.2 (9.85; 14.6)	11.1 (8.7; 13.5)	11.6 (9.2; 14.1)	-0.53 (-3.99; 2.92, p=0.761)
Relationship happiness scale	35.5 (31.5; 39.5)	34.7 (30.7; 38.7)	44.45 (40.3; 48.6) ††	44.7 (40.6; 48.9) ††	-0.28 (-6.15; 5.58, p=0.924)
Satisfaction with Life Scale	22.8 (21.2; 24.3)	23.8 (22.2; 25.3)	23.4 (21.8; 25.0)	23.7 (22.05; 25.3)	-0.28 (-2.53; 1.98, p=0.810)
EQ5D visual analogue scale	68,4 (64.0; 72.8)	70,2 (65.75; 74.7)	70.9 (66.4; 75.5)	75.8 (71.1; 80.4) †	-4.84 (-11.38; 1.69, p=0.145)
Parental Self-Efficacy Scale	256.8 (244.1; 269.5)	252.8 (239.9; 265.7)	268.3 (255.25; 281.3) †	271.9 (258.45; 285.3) †	-3.59 (-22.27; 15.10, p=0.705)

[a] Note that the range of *n* varies, mainly due to some missing data regarding substance-/alcohol consumption. [b] All reported confidence intervals are at the 95 % level. [c] Because the measure is accumulated, reported percentages are relative to baseline. DUDIT = Drug Use Disorders Identification Test, AUDIT-C = Alcohol Use Disorders Identification Test, DASS-21 = Depression Anxiety Stress Scale

† Statistically significant within-group difference compared to baseline at p<0.05

†† Statistically significant within-group difference compared to baseline at p<0.001

Parents in both conditions reported an increase in relationship happiness and parental self-efficacy from baseline to 24 weeks but with no differences between conditions (table 6). No change in parental depression, anxiety or stress was found, and baseline levels were sub-clinical (table 6). The parents receiving counselling also reported an increase in quality of life according to EQ5D-VAS, but with no differences between conditions (table 6).

Per-protocol analyses were consistent with the ITT-analyses, except that young adult TLFB for alcohol that favored CRAFT in the ITT-analyses, did not remain (not displayed).

There was no significant difference between conditions regarding satisfaction with treatment (CSQ-8) at the post-intervention (12 week) follow-up (mean = 26.4 (SD = 5.0) for CRAFT vs 25.1 (SD = 4.4) for counselling) (U = 959, p = 0.088) (not displayed).

3.4 STUDY IV: 'BEFORE, WE ENDED UP IN CONFLICTS, NOW WE CAN PROVIDE SUPPORT' - EXPERIENCES OF COMMUNITY REINFORCEMENT AND FAMILY TRAINING (CRAFT) FOR PARENTS OF YOUNG ADULTS WITH HAZARDOUS SUBSTANCE USE.

3.4.1 Methods

Aim: To explore the parents' descriptions of reasons for entering the CRAFT program, which CRAFT components that were considered the most and least helpful. The aim was also to identify adaptations of CRAFT to the target population.

Design: Qualitative study based on interviews with parents who had participated in CRAFT in study III. The Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong, Sainsbury, & Craig, 2007) was utilized to foster transparency of the qualitative research process.

Participants: Purposive sampling was used, and parents were approached following completion of the 24-week follow-up assessment (primary end-point) of study III. In total, 15 potential participants were approached of which one did not answer, four declined due to lack of time, and one did not show up on the appointed time. In total, nine interviews were conducted, but with a total of ten informants due to that one co-parent, who had been a part of all CRAFT sessions together with the other co-parent, also participated in the interview.

Data collection: All interviews were conducted by authors OS or JS between September 2021 - May 2022 via videoconference or by telephone and lasted 30-60 minutes. The participants were encouraged to be frank about their experiences since such an approach was of importance in order to provide valid information in evaluating program content and future adaptations for clinical practice. The interviews followed a semi-structured interview guide with open-ended questions and suggestions for prompts and examples. Examples of central questions were: "What did you hope that CRAFT could help you and your son/daughter with when you applied?" and "In what way has the program affected your son's/daughter's use of alcohol/substances?". The participants were also asked specifically

which CRAFT sessions they had found most and least helpful. The interviews were recorded and subsequently transcribed verbatim by a professional transcriber. For a full description, see (Siljeholm, 2023a).

Data analyses: A thematic analysis was performed on the complete data set using the method described by Braun and Clarke (Braun V, 2006). The purpose was to summarize and interpret the data content in relation to the study aim using an inductive approach. The analysis comprised six phases: 1) Data familiarization, 2) Generating codes, 3) Searching for themes, 4) Reviewing themes, 5) Defining and naming themes, and 6) Producing the report. This iterative process was conducted via both physical and digital meetings. The close involvement in the RCT (study III) of author OS came with a risk of bias, so in order to manage prior knowledge or pre-understanding of CRAFT, the data analysis was primarily carried out by authors JE and OM, who had not been involved in the project previously. In the final phase, authors OS, JE, OM and AH were involved in finalizing the results with JS providing feedback.

3.4.2 Results

The results were divided into three overall domains that corresponded to the research questions: *Reasons for entering the CRAFT program*, *Strengths of the CRAFT program* and *Limitations of the CRAFT program*. Under each domain, three or four themes were created (see Table 7).

Table 7. Overview of the results from the thematic analysis. The arrows illustrate that there is a process between themes, meaning that the previous theme created conditions for, or led to, the following theme.

DOMAINS	REASONS FOR ENTERING THE CRAFT PROGRAM	STRENGTHS OF THE CRAFT PROGRAM	LIMITATIONS OF THE CRAFT PROGRAM
THEMES	Feelings of powerlessness ↓ Easily accessible support ↓ Gain increased knowledge and strategies to help young adults	Acquired communication skills ↓ Shifted focus from substance use to encouragement ↓ Improved relationship ↓ Helped young adults to reduce substance use and to seek treatment	Difficulties to practice CRAFT components Lacked follow-up for parents Challenges when trying to influence substance use Insufficient support and treatment options for young adults

3.4.2.1 Reasons for entering the CRAFT program

The main findings were that the parents greatly appreciated the possibility of accessible support at a time when they needed it due to feeling that they had no control over their situation or ability to help their young adults. They described a mix of emotions, including frustration, powerlessness, and a feeling of shock and not knowing what to do. Some parents reported that substance use had been present for five years, while other had found out last week, but a common wish was to gain increased knowledge and strategies to help their young adults.

3.4.2.2 Strengths of the CRAFT program

The parents stated that communication strategies and positive reinforcement were the two most helpful CRAFT sessions. Together, these skills helped them improve the relationship with their young adults, through less conflicts and more honesty between each other. Further, their new strategies were perceived as contributing to the young adults reevaluating their views on substance use, and in some cases becoming open to receive treatment.

3.4.2.3 Limitations of the CRAFT program

The main results were that parents lacked easily accessible treatment alternatives for the young adults when these were ready to enter treatment, and difficulties to practice some CRAFT-components. Fear of aggravated health, or even suicide, led to some parents having difficulties to let the young adults handle all potential negative consequences of substance use. Lastly, due to changing life-circumstances as the young adults were growing older and more interested in other social networks than the family, some parents found it hard to influence their young adults. The results in this domain were the basis for suggestions of adaptations of CRAFT for parents of young adults, which is addressed in the discussion section.

3.5 ETHICAL CONSIDERATIONS

All studies in this thesis have undergone ethical review and received approval, ensuring compliance with the principles outlined in the Declaration of Helsinki ("World Medical Association Declaration of Helsinki," 2013). All studies were conducted in accordance with Good Clinical Practice (GCP) and all study personnel had undergone such training.

In studies regarding sensitive issues such as mental health problems, alcohol- or substance use, participants might find parts of the study uncomfortable or violating. In all studies conducted, the team of researchers were experienced clinicians and were familiar with the

target population, how to handle issues that might arise and knowing where to refer the participants if needed.

To minimize negative consequences for the participants, participants in the studies were informed that participation was completely voluntary and that they were free to withdraw from the study at any time without having to give a reason. Only aggregated data has been published from studies I and III, which cannot be traced to any specific person. Further, all data was stored according to guidelines, ensuring that the privacy of the participants was secured. In studies II and IV, participants details were altered, preventing any individual from being identified by readers.

Participation in studies involving behavioral changes in CSOs can potentially lead to irritation, aggression, and violence from the substance-using relative (Meyers, Miller, Hill, & Tonigan, 1998a; Smith & Meyers, 2004). To address this, violence risk was assessed in the recruitment process. In study I, an unexpectedly high proportion of CSOs were ineligible for participation due to co-parent violence. To respond, the excluded CSOs were contacted via email and offered participation in a new treatment arm, providing SPARE with optional therapist support, after first obtaining ethical approval from the Swedish Ethical Review Authority.

The designs in studies I and III entailed offering CSOs non-evidence-based support programs, which is self-evident since no previous research existed and the target populations were not offered any treatment options. Further, since no previous support programs existed, the participants were not withheld of any support that was expected to be helpful, which is another ethical consideration when conducting an RCT. Great energy was devoted when designing the studies to ensure that all participants would receive an intervention that was helpful, or at least not harmful. The procedure of ethical approval ensures that professionals outside of the research team agree that the studies were considered safe. Such approval was received for both projects, together with amendments for all subsequent alterations.

4 DISCUSSION

The overall aim of this thesis was to investigate novel approaches of supporting CSOs applying programs based on CRAFT. The first two studies involved investigation of the online self-directed intervention SPARE for CSOs sharing a child with a co-parent with problematic alcohol consumption via an RCT, with the primary aim to improve children's mental health (study I) and interviews with CSOs who had participated in the program (study II). The second two studies involved investigating CRAFT for parents of treatment-refusing young adults with problematic substance use, via an RCT with the primary aim to engage more young adults in substance use related treatment (study III) and through a qualitative study exploring the participants experiences (study IV).

Main findings from study I-II showed that we could not provide evidence that SPARE was efficacious in improving children's mental health and that it was difficult to recruit the target population. Participants in both conditions reported a decrease in co-parent drinking and an increase in perceived ability to protect the children from effects of co-parent drinking consequences. CSOs perceived SPARE as empowering, as well as contributing to improvements in the relationship to their children. Main findings from study III-IV showed that both CRAFT and the counselling program were efficacious in increasing treatment-seeking among young adults with problematic substance use, in decreasing young adult use of alcohol and illicit substances, and in improving relational happiness and parental self-efficacy. The parents perceived CRAFT to be valuable by providing knowledge and strategies that resulted in an improved relationship to the young adults, a decrease in substance use, and in some cases treatment entry. However, better access to young adult treatment options were called for.

4.1 DISCUSSION REGARDING SPARE (STUDY I AND II)

As to why no significant effect was found in the primary outcome children's mental health, the transformation and merging of CRAFT and ABC manuals in this study is a potential reason. Brief CRAFT interventions have shown similar efficacy to longer programs (Hellum et al., 2022; Manuel JK, 2012) but previous trials have not employed child related outcomes, which hinders comparisons. Although self-directed online parenting interventions have shown to be efficacious (Florean et al., 2020) it is possible that our dual-focused program with reduced content may have been too complex to effectively facilitate parenting-related behavior change as intended.

The failure to meet target sample size (N=76 of a planned N=300), for which the study was powered, must be considered as another possible explanation to the null results. A post-hoc power analysis on the primary outcome SDQ indicated that the difference between SPARE and psychoeducative information at 12 weeks would likely have been statistically significant with a sample size of N=270, i.e., slightly below the intended sample size. The difficulty in recruiting from the target population was intriguing in the context of the high prevalence (10-20 %) of children in Sweden affected by parental alcohol problems (CAN,

2019). The slow recruitment pace could either indicate that the trial's advertisement did not speak to the intended population, or that the treatment seeking proneness of the target group was overestimated, but there is no evidence in the current data for either suggestion. It is possible that the perceived need for support among CSOs with drinking co-parents generally arise at a later stage, presumably after seeing a deterioration in co-parent functioning and identifying negative impact on the affected children. This inference find support in a recent Swedish qualitative study with 23 female CSOs sharing a child with a male co-parent (Ekström & Johansson, 2021). The CSOs described severe alcohol- or substance use problems, major parental neglect from the fathers and children with delinquent behaviors as a cause of the paternal substance use. The CSOs all identified themselves as being parents to a child who fare ill as a consequence of co-parent drinking, an identification which appear to not have been shared with the CSOs in study II. Few CSOs participating in study II perceived the consequences of the co-parents' consumption as severe enough to cause the children serious harm. Some of the CSOs mentioned that they had started to worry about how the drinking affected the children, but mainly as a future risk if the drinking continued. However, it is also possible that the participants in study II represented a less affected sample than the study population in study I and were unrepresentative of the target population. Future studies are necessary in order to better understand which factors that lead CSOs who share a child with a drinking co-parent to seek for support.

The child mental health score (SDQ) reported by CSOs at baseline (mean = 11.88) was higher than the Swedish population mean, which is between 4-7 depending on age group (Dahlberg, Falt, Ghaderi, Sarkadi, & Salari, 2020). From a clinical standpoint, the baseline SDQ scores represent what would be considered as indications of deteriorating mental health among the children in focus of the study. Parental drinking problems is associated with higher levels of inconsistent parenting compared to non-drinking parents, for example by responding differently to similar situations, or displaying sudden mood swings, which may lead to increased levels of stress for the child (Alexanderson & Näsman, 2017; Park & Schepp, 2015). Since no measures on co-parents' behaviors were included in the study, it is not possible to conclude that the high level of impairment in child mental health is related to inconsistent parenting due to drinking, but the results nevertheless support the call for the development of efficacious support programs for children affected by parental drinking problems.

It was surprising that participants in both conditions reported similar improvements in co-parent alcohol consumption and dependency, as well as parental self-efficacy in handling effects of co-parent alcohol-related behaviors (PSE-A). This is noteworthy considering that the psychoeducative information contained substantially less material compared to SPARE. Increased level of self-efficacy is achieved through experiences of mastering situations related to the particular domain (Bandura, 1977a). The information provided in both programs appear to have sufficed in order for CSOs to experience an increased mastery in issues arising from co-parent alcohol related behaviors. These results align with the research on the SSICS-model, and the subsequent notion that relevant information provided to CSOs is one of the key aspects in the 5-step method (Copello et al., 2010a; Orford, Copello, et al., 2010). Additionally, these findings further align with studies where

information material performed equally well as Coping Skills Training (Hansson, 2004; Zetterlind et al., 2001). However, this trial lacked measurements on coping skills or CSOs behavior change vis á vis the co-parent and can hence not conclude if such behavioral components were involved and could explain the increase in PSE-A rather than information material alone. The equal results between the conditions in study I warrants future qualitative studies in order to untangle the effects of psychoeducative interventions.

In study II the main perceived effects of SPARE described by the CSOs were acknowledgement and support which empowered the CSOs to question their co-parents, increase own positive activities and spend more time with their children. Altogether this shift in focus was described as contributing to less perceived strains, irrespective of eventual decreases in co-parent drinking. These findings could be understood through the lens of the SSICS-model (Orford, Copello, et al., 2010). Support and information (from SPARE) were described by CSOs as leading to more functional coping behaviors and less impact from co-parent drinking, which, according to the SSICS-model is suggested to decrease the total amount of perceived strain. This interpretation of CSOs perceived effects of SPARE shows that the SSICS-model also captures experiences of CSOs with somewhat lower levels of accumulated burdens.

Finally, a majority of the CSOs described an increased focus on their children as a direct effect of SPARE. After setting aside 15 minutes daily for dedicated parent-child time, the CSOs described fewer child-conflicts, having more fun together, and a more open communication. The protective factor of a good relationship with one parent when the other parent has substance use problems is well-established (Park & Schepp, 2015; Velleman & Templeton, 2016) and it is suggested that study II indicates that SPARE, when completed, led to an improved parent-child relationship.

4.2 DISCUSSION REGARDING CRAFT FOR PARENTS (STUDY III AND IV)

The proportion of young adults entering treatment in the CRAFT condition (33 %) in study III was on an estimated level, but the control condition was unexpectedly efficacious considering that the interventions differed substantially regarding focus on behavior modification. The counseling program may have influenced parental behavior, leading to increased treatment seeking among young adults. However, it is currently unclear which components in CSO support programs are associated with improved treatment entry, and further research on active mechanisms is called for (Merkouris, Rodda, Aarsman, Hodgins, & Dowling, 2023). One potential reason for the null finding on the primary outcome was that all parents were highly motivated to get their young adults into treatment. CSOs having a primary goal of relatives' treatment entry has rendered higher rates compared to CSOs in CRAFT primarily focused on improving their own well-being (Bischof, Iwen, Freyer-Adam, & Rumpf, 2016). High parental motivation to facilitate treatment entry, together with unidentified effective components, may hence have masked any additional effects of the CRAFT program.

The findings on reductions in alcohol and drug consumption found in both conditions are in line with the results in a study by Waldron et al, in which adolescents reduced their use (Waldron et al., 2007). The result is also in line with CRAFT trials for adults, consistently reporting significant within-group reductions, but with no differences between groups (e.g. Bischof et al., 2016; Eék et al., 2020a; Meyers et al., 1998b)). Hence, it is inferred that both conditions in the present study provided the participants with strategies that resulted in a substantial decrease in use of both illicit substances and alcohol.

Possibly related to the decreased substance use, both CRAFT and manualized counseling resulted in increased parental self-efficacy (PSE). These outcomes are intriguing since neither intervention included traditional parenting components associated with improved PSE. A previous study on an alcohol use prevention program for students found that increased parental rule-setting mediated enhanced PSE (Glatz & Koning, 2016), which could potentially elucidate the results in study III. Both interventions incorporated strategies for preventing and addressing substance use, which can be seen as operationalizations of rule-setting, and hence explain the observed increase in PSE. Interviews with parents (study IV) revealed that many participants felt empowered and gained strategies to help their young adults reduce substance use, improve communication, and build relationships.

Participants' relationship happiness increased significantly in both conditions showing an improved relationship with the young adult. An increased relationship happiness following CRAFT participation for parents to young adults is in line with Waldron et al (Waldron et al., 2007) and several trials on CRAFT in adult populations (e.g. Bischof et al., 2016; Eék et al., 2020a). Increased relational happiness may stem from participants focusing more on positive aspects of their young adult´s behaviors, a treatment component that was included in the manuals in both conditions.

The importance of easily accessible support for CSOs has been described in previous research, for example as means to reduce stigma, to validate, empower and provide knowledge and coping strategies the CSOs, to increase the quality of life to the CSOs and to possibly improve the relatives' substance use (Hellum, Bilberg, & Søgaard Nielsen, 2021; McCann & Lubman, 2018a; Orford, Velleman, et al., 2010). It was found that the parents' main reasons for seeking support (study IV) were related to feelings of shock after discovering that their young adults used substances and that parents felt powerless following unsuccessful attempts to decrease the frequency of substance use, together with a wish to gain strategies to affect their young adults. Similar themes of shock and powerlessness have been described in several other studies on parents of substance using young adults (e.g. Choate, 2015; Liahaugen Flensburg, Johnson, Nordgren, Richert, & Svensson, 2021; Richert et al., 2018), and a desire for knowledge regarding substances and new strategies has been mentioned as a reason to enter CRAFT also in other contexts (Hellum, et al., 2021; Osilla et al., 2018). The parents' accounts of how crucial it was to receive support when needed is considered a main finding in study IV and an argument for the implementation of support programs for parents into regular health care.

A vast majority of the parents in study IV expressed that they lacked easily accessible treatment options for their young adults when they expressed motivation to seek help. Several parents stated that they did not know where to turn or that their young adults were not offered an appointment promptly by a treatment clinic. Hence, it is plausible that the treatment engagement rate in study III might have been even higher if there would have been an option for integrated treatment for the young adults. This statement finds support in the CRAFT-literature where when treatment options provided in-house most often have resulted in higher treatment engagement rates than if potential patients were required to seek treatment outside study sites (e.g. Archer et al., 2020; Kirby et al., 2017; Meyers et al., 1998b). Based on the results in study IV, it is proposed that CRAFT for parents optimally should be provided in a context where the young adults can participate in easily accessible parallel treatment.

The main suggested adaptation to CRAFT from the findings in studies III and IV is related to an acknowledgement of the strength of reinforcers of young adult behaviors from contexts outside of the family mentioned by several parents in the interviews. It is proposed that therapists and parents in CRAFT should investigate the young adults' social networks within sessions in order to identify positive relations to promote, a component which was included in the counseling manual and that might have contributed to the equal results between the conditions. The data in study III did not contain any measurements to investigate the effects of highlighting social networks, but in the SSICS-model and the 5-step method, exploration of CSO's social networks is considered an important component involved in reducing strain caused by the relative's substance use (Copello et al., 2010a; Orford, Copello, et al., 2010). The research on SSICS and 5-step hence provide some support to the suggested inclusion of investigating the young adults' social networks in CRAFT for parents of young adults.

Finally, parents in study IV expressed ambivalence regarding allowing natural consequences for their young adults' substance use. Some parents feared their young adults would suffer severe consequences or even commit suicide, which led to continued protective behavior. Similar ambivalence was reported by Nordgren et al. (2020), who found that extreme measures, like throwing adult children out of the house, resulted in guilt and shame without positive changes (Nordgren, Richert, Svensson, & Johnson, 2020). While reflecting on natural consequences can be helpful, CRAFT-therapists should consider the unique dynamics of parent-child relationships and exercise caution and empathy when advising on natural consequences. These are directives already included in the original CRAFT manual (Smith & Meyers, 2004), which provides a good argument in favor of the fitness of CRAFT for parents of young adults with a problematic substance use.

4.3 LIMITATIONS

There are some general and some specific limitations that should be mentioned. The first general limitation regards that all outcomes concerning the substance using relatives were reported secondhandedly by the CSOs and could not be corroborated by relatives' self-reports or clinicians' reports. However, previous research has shown moderate

correspondence between CSO-reports and self-report regarding alcohol (especially if the relationship is close) (Witkiewitz, Finney, Harris, Kivlahan, & Kranzler, 2015) and an acceptable correspondence between parental and adolescent reports on substance use (Piehler, Lee, Stockness, & Winters, 2020; Waldron et al., 2007) and it is hence assessed that the reports in the trials provide sufficient reliability.

The second general limitation regards the samples of CSOs in the studies, which were not representative regarding socioeconomic factors compared to the Swedish population in general. For example, level of education was comparably high among participants in our studies. This issue should call for some self-examination of the study teams involved and lead to considerations of alternative strategies of recruitment in efforts to reach a more representative study population.

The third limitation regards the samples for both of the qualitative studies. It is possible that interviewing only participants who made it through half or more of the programs might have led to a risk for survival bias. This potential bias entails that important information from "non-survivors" might have been missed, information that could have been useful in the qualitative assessments and subsequent adaptations of the interventions.

Regarding study I, recruitment was terminated before reaching the target sample size, resulting in reduced statistical power. Attrition rates during follow-up were high, although consistent with similar self-directed internet intervention studies (Dadds et al., 2019). Expecting high attrition rates, a mid-intervention follow-up was included in the study design during the planning phase to enable the use of appropriate statistical analyses, and to better account for potential missing data. Another limitation in study I was the lack of factor analysis to assess the construct validity of the shortened version of Parental Self-efficacy and the novel scale PSE-A. While the psychometric properties of the original scales, and previous research (Ulfsdotter et al., 2014), provide some certainty, caution is advised when interpreting the results.

One potential limitation regarding study II was that the first author was intimately involved in the RCT. This involvement naturally results in a risk of bias in the interpretations of data, potentially leading to more positive interpretations than by a "neutral" observer. This risk was emphasized already from the start of the study and was counteracted via continuously discussing analysis and results back and forth between the authors.

Regarding study III, since no non-active control group was included in the trial, analyses of direct intervention effects compared to no treatment was not possible. Hence, it cannot be ruled out that improvements in both conditions stemmed from natural trajectories of parents seeking help. However, a recent meta-analysis on support programs for CSOs indicated positive effects of various psychosocial interventions compared to non-active control groups, including improvements in treatment entry (Merkouris et al., 2022b). It is reasonable to propose that the control condition functioned as a psychosocial intervention in itself. Therefore, it can be inferred that the observed results in study III were likely attributable to the effects of interventions rather than natural changes in parental help-seeking over time.

5 CONCLUSIONS

Study I. No between-groups effects favoring the SPARE program over information material could be proven, but the study suffered from limited statistical power, also showing that the target population was difficult to recruit. The results on the SDQ showed that the children's mental health assessed by parents were at almost clinical levels, meaning that the children were affected, which confirms the importance of providing support for children/parents in this situation. Within-group changes in the sample as a whole indicate that both SPARE and structured information material improve the CSOs' self-efficacy in handling co-parent alcohol related situations, and that both interventions can facilitate behavior changes in the CSOs that affect the co-parents' alcohol use. Caution when interpreting the results is however needed due to the limited statistical power and high attrition rates. Finally, the large number of CSOs excluded from participation due to experiences of co-parent violence suggest that future trials should prepare for inclusion of CSOs who report living in such environments.

Study II. In the study, a group was reached that had not previously (to the author's knowledge) been represented in the literature, namely CSOs of individuals with milder forms of alcohol problems. However, the reasons for entering the program described by the CSOs in the study (the CSOs' own emotional needs deriving from co-parent drinking, trying to understand or cope with consequences from the co-parent's drinking) was coherent with previous research which shows how the Stress-Strain-Information-Coping-Support-model is applicable to CSOs with different levels of accumulated burdens. Anonymity and availability (internet-based, self-delivered) was important in order to facilitate entering the support program, and being acknowledged as living under straining circumstances was expressed as helpful and empowering. For those CSOs who completed more than half of the program, it had led to a better relationship to their children due to spending more time together, a result described as fulfilling by the CSOs.

Studies I & II together show that the target population was hard to reach since the CSOs did not identify their children as being clearly harmed by co-parent drinking. Anonymity was important in order to facilitate entering the support program. Dedicated parent-child time is recommended to include in similar interventions, but information material might suffice to affect co-parent drinking.

Study III: The results from this trial suggest that both CRAFT and the manualized counselling program increase treatment-seeking among young adults with problematic substance use, and decrease young adult use of alcohol and illicit substances. However, the lack of a non-active control condition hinders definitive conclusions regarding treatment efficacy. The young adult substance use at baseline was assessed as high by the parents, and the reductions seen in both conditions were clinically relevant. This is of great significance when arguing for the implementation of support interventions to parents of treatment refusing young adults in the health care system, which potentially could have major public health benefits through the decrease in young adult substance use.

Study IV: The parents found CRAFT to be valuable by providing strategies that resulted in an improved relationship to the young adults, in several cases a decrease in substance use, and in some cases that the young adults sought treatment. The results showed that CRAFT is suitable for the current population, but with some possible adaptations due to the importance of social networks outside of the family, and changing circumstances as part of the developmental phase emerging adulthood.

Studies III and IV together show that there is a need for easy access support for parents of substance using young adults, and a need for the health care system to provide treatment to the young adults at times of higher treatment motivation. Manualized support programs for parents provided by care-providers specialized in alcohol- or substance use disorders are highly feasible and wanted by both parents and treatment personnel. The results provide arguments for the health care system to implement support interventions to parents of young adults with problematic alcohol- or substance use.

6 POINTS OF PERSPECTIVE

6.1 A CRITICAL DISCUSSION ON CRAFT

With a growing body of studies conducted on CRAFT in different contexts, it has become evident that there is a notably large variability between studies in treatment engagement among substance using relatives (Archer et al., 2020). In general, studies conducted in the US show higher rates of treatment engagement compared to e.g. European studies. Factors related to treatment context have been suggested to play an important role in explaining the large variability (Bischof et al., 2016). While treatment for SUD in Europe is often easily accessible and cost-free (Bischof et al., 2016), SUD-treatment in the US often relies on private insurance coverage or economic resources, which excludes many individuals from treatment (e.g. Wen, Cummings, Hockenberry, Gaydos, & Druss, 2013). It is hence possible that substance using relatives in US contexts have additional incentives for entering treatment free of charge as part of a study, which could lead to inflated treatment engagement rates compared to European contexts.

Moreover, studies on CRAFT have received low ratings of scientific quality, with potential biases in participant selection, blinding, and data collection (Archer et al., 2020). Although study quality was not found to be related to relative's treatment entry rate reported in this systematic review (Archer et al., 2020), ensuring good scientific quality is vital for future CRAFT studies, for example by pre-registering study protocols and providing access to data.

Further, the knowledge of which specific CRAFT components are related to a favorable outcome is limited, and more research is called for in this respect. To illustrate, Kirby et al (2017) investigated an abbreviated version of CRAFT (TEnT) that focused on treatment entry and communication training in four to six sessions. No difference in treatment engagement between the CSOs who received the full CRAFT (12-14 sessions) and those who received TEnT was found (Kirby et al., 2017). Another suggested example of a factor associated with treatment entry is CSO's primary motivation for engaging in treatment. In the study by Bischof et al., (2016), a secondary analysis revealed that CSOs who primarily participated in order to engage their relative in treatment had better success than those who entered to increase their own wellbeing (Bischof et al., 2016).

To summarize, more thorough studies on which components that contribute to treatment outcome in CRAFT is warranted, together with more rigorous and transparent study designs in future trials.

6.2 HARMONIZATION OF OUTCOMES

An important point is to harmonize at least some of the assessment outcomes applied in future trials on CSO-interventions, something which was also pointed out in several

systematic reviews in the field (Kourgiantakis et al., 2021; Rushton et al., 2023; Shorter et al., 2023). One suggestion of such an instrument is The Family Member Questionnaire (Orford, Cousins, Smith, & Bowden-Jones, 2017). The FMQ measures how the relative's substance use affects the CSO, including physical and psychological symptoms, coping skills, and perceived support. FMQ provides a measure of the total family burden experienced by the CSO, which is inferred to represent outcomes that most unilateral interventions aim to affect. A harmonization of outcomes would enable for meta-analyses to investigate the effects of CSO-interventions, which in turn could facilitate for researchers to communicate results to policy makers and other stakeholders in order for CSO-interventions to be implemented in health care or social services.

6.3 HOW TO REACH MORE CONCERNED SIGNIFICANT OTHERS WITH SUPPORT PROGRAMS

One question for future research identified in this thesis, especially through studies I and II, is how to attract more CSOs to enter the existing support programs. It was evident in study II that the CSOs did not identify as parents of children faring ill of the co-parents' drinking, at least not yet. The growing body of evidence regarding children being affected by milder forms of parental alcohol problems shows the necessity to reach these children, or their parents, earlier in the development of parental drinking (Ramstedt et al., 2022, 2023; Thor et al., 2022). It is suggested that a reduction in stigma regarding substance use is likely to have an impact on the CSOs' propensity to seek support. Approaches to try and reduce stigma regarding AUD/SUD have shown effects from educational interventions for the general public (Livingston et al., 2012). Information to the general public on mental illness as a continuous concept has been show to decrease public stigma through reducing the notion of differentness (Peter et al., 2021). Similar educational interventions on substance use as a continuum rather than as dichotomous ("addict" vs no problems) to the public could potentially decrease stigma (Wallhed Finn et al., 2023), and a corresponding decrease in perceived stigma is assumed to be helpful also to CSOs. It is also suggested for future research to investigate if interventions to reduce self-stigma in individuals with mental health illness, such as therapist led group interventions based on CBT-strategies to influence internalization of public stigma (Corrigan & Rao, 2012), could have similar effects also regarding self-stigma for CSOs.

6.4 UNDERSTANDING THE GENDER IMBALANCE

The majority of CSOs in both RCTs included in this thesis were female (96 % and 92 % respectively), consistent with previous CRAFT trials and other CSO-intervention studies (Archer et al., 2020; Merkouris et al., 2022; Rushton et al., 2023; Shorter et al., 2023). Although alcohol problems are more prevalent in men globally, the gender imbalance in the studies does not reflect the proportion of male/female drinkers. Female CSOs tend to experience greater burdens than males, likely contributing to the gender asymmetry (Orford, 2017; Orford, Velleman, et al., 2010). Further, norms have been described to socialize women to be sensitive and to verbalize discomfort, while men are taught to be tough and to tolerate pain (e.g. Myers, Riley, & Robinson, 2003). Men also delay help

seeking and are less inclined to initiate couple's therapy compared to women, which has been suggested as an effect of masculine norms such as "sharing emotions is not helpful", or "men should be in control in a relationship" (Parnell & Hammer, 2018; Yousaf, Grunfeld, & Hunter, 2015). In studies III and IV, the gender imbalance is inferred to stem from differences in perceptions of parenting roles, where women are generally expected to have the primary responsibility (Ekström & Johansson, 2020). Hence, social, cultural, and gender norms likely play a role in the observed gender imbalances, emphasizing the need for further research on attracting more men to seek support as CSOs.

6.5 CLINICAL IMPLICATIONS

Overall, the studies in this thesis suggest that support programs for CSOs should be offered in a greater extent than to date, irrespective of participation of the substance using relative.

Regarding studies I and II, the clinical implications include that providing easy access, online, anonymous support is a feasible way to lower the help-seeking barriers for CSOs of individuals with problematic substance use, which is in line with previous research (McCann & Lubman, 2018a; Osilla et al., 2018). Providing information regarding alcohol use, dependence and other relevant factors appear to have been sufficient to create a change in context, leading to improvements on CSOs self-efficacy to handle alcohol related situations and a decrease in co-parent drinking. These results are in line with several previous trials showing that relevant information material can lead to corresponding results as structured interventions (e.g. Zetterlind et al., 2001). It also aligns with the SSICS-model and 5-step method that has shown the potential in providing relevant information and referrals to further help if needed (Copello et al., 2010a; Van Beek et al., 2023), which was a part of the psychoeducative information in study I. The SPARE-program achieved the same results, but failed to demonstrate effectiveness regarding improvements in children's mental health. However, the feasibility of SPARE aimed at the target population in the trial can be questioned, since most CSOs who applied to the trial were excluded. Hence, a potential future version of SPARE should include a more specific section on exposure to violence in order to be properly adapted to the group that looks for support.

Regarding studies III and IV, the results show that there is a demand for support among parents of substance using young adults, and that both CRAFT and the manualized counseling program could meet up to this demand. The high ecological validity exhibited in study III, where the therapists working at the involved clinics also delivered the interventions, show that implementation is possible. This could mean a potential addition to the existing range of treatments that would be highly welcomed by both staff and parents. Studies show that clinicians are happy to provide support for CSOs if only they know what to do with them (Orford, Velleman, et al., 2010; Velleman, 2023), so it is of importance to provide personnel working in relevant organizations with a structured support program. As such, both CRAFT and the manualized support program are deemed adequate, and are ready to be implemented.

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