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Creating Lasting Family Connections Program

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Name of Model

The Creating Lasting Family Connections[®]
(CLFC) Program

Introduction

Creating Lasting Family Connections (CLFC) is a manualized, family focused program to increase parenting skills and family-relationship skills to build the resiliency of youths aged 9–17 years, to increase alcohol and drug knowledge and attitudes, to reduce the frequency of alcohol and other drug (AOD) use, and to increase family use of needed community services. CLFC is designed to be implemented through community systems such as mental health centers, churches,

schools, recreation centers, and court-referred settings. There are three modules for parents and three separate modules for their children.

CLFC Program Modules for Adults

Raising Resilient Youth. Participants learn and practice effective communication skills with their families, friends, and coworkers, including listening to and validating others' thoughts and feelings. Participants also enhance their ability to develop and implement expectations and consequences with others, including children, spouses, coworkers, and friends. This training enhances a sense of competence, connectedness, and bonding between parent and children and other meaningful relationships (Strader and Noe 1998a).

Developing Positive Parental Influences. This CLFC training component helps participants develop a greater awareness of facts and feelings about substance use, abuse, and dependency; review effective approaches to prevention; and develop a practical understanding of intervention, referral procedures, and treatment options. This module includes an examination of childhood and family experiences involving AOD, personal and group feelings and attitudes toward AOD issues, as well as an in-depth look at the dynamics of chemical dependency and its impact on relationships and families (Strader and Noe 1998b).

Getting Real (Same content for both Adult and Youth Modules). The Getting Real training is provided separately to groups of adults and youth. Participants examine their responses to the verbal

and nonverbal communication they experience with others. Participants receive personalized coaching on effective communication skills, including speaking with confidence and sensitivity, listening to and validating others, sharing feelings, and matching body language with verbal messages. This promotes the skills of self-awareness and mutual respect while focusing on helping participants combine thoughts, feelings, and behavior in a way that leads them to generate powerful, meaningful, and palatable messages to others (Strader et al. 1998).

CLFC Program Modules for Youth

Developing Independence and Responsibility. In this component, youth are asked to examine their current level of personal responsibility in their family life, with an eye toward developing personal independence and responsibility for adulthood. Youth are asked to visualize themselves in the future role of parents, coworkers, supervisors, or other adults responsible for setting appropriate expectations and consequences for their children or others they may need to supervise in areas of responsibility (Strader and Noe 1998c).

Developing A Positive Response. This module helps young people to become aware of their deepest wishes for their own personal health, their relationships with their peers and family members, and their yearning for success. With exercises designed and facilitated with sensitivity to remain inclusive and nonjudgmental, participants examine information, facts, and feelings about alcohol, tobacco, marijuana, and other drug exposure (and possible use) in family, peer groups, community, and media. This module also helps youth develop an appropriate “worldview” of alcohol and other drug issues with a focus on personal and family health (Strader and Noe 1998d).

The six modules of the CLFC curriculum are administered to groups of parents/guardians and their children in 18–20 weekly training sessions. While the sessions are typically provided in the same facility at the same time, the parents and youth meet in separate training rooms with different group facilitators. Youth sessions last 1.5 h and parent sessions last 1.5–2.5 h. The curriculum focuses on (1) imparting knowledge about AOD

use; (2) improving communication and conflict resolution skills; (3) building coping mechanisms to resist negative social influences; (4) encouraging the use of community services when personal or family problems arise; (5) engendering self-knowledge, personal responsibility, and respect for others; and (6) delaying the onset and reducing the frequency of AOD use among participating parents and youths. The program includes optional individual, couple, and family case management sessions to identify any need for specific therapeutic interventions and specialized referrals to other community services. A 6–9-day CLFC Certification Training for therapists (and other providers) along with all materials necessary for implementation are available from the program developer.

The CLFC Program is one of three programs comprising the *Creating Lasting Family Connections (CLFC) Curriculum Series*. The Series also includes the *CLFC Fatherhood Program* and the *CLFC Marriage Enhancement Program*. The *CLFC Curriculum Series* addresses the intergenerational and chronic nature of addiction and the family’s role in both recovery and prevention. The *CLFC Series* represents the intersection of treatment and prevention services for families (Strader et al. 2013). Each of the three CLFC programs is separately listed on the SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP).

Prominent Associated Figures

The *Original CLFC Program* was developed in the late 1980s by Ted N. Strader, M.S., a Certified Chemical Dependency Counselor, a Certified Prevention Specialist, and Executive Director of the Council on Prevention and Education: Substances, Inc. Dr. Tim Noe and Warrenetta Crawford Mann provided notable assistance in program development. Teresa Strader, L.C.S.W., and Christopher Kokoski assisted with the development of support materials. The CLFC curriculum has been recognized on the National Registry of Evidence-based Programs and Practices (NREPP) as an Exemplary Program by Healthy Canada’s Compendium of Best Practices, and a

four-time winner of the Exemplary Program Award provided by the National Association of State Alcohol and Drug Abuse Directors, SAMHSA's Center for Substance Abuse Prevention, and the National Prevention Network. The John C. Maxwell Leadership Team named Mr. Strader one of the top 10 leaders in the USA serving youth and families.

Theoretical Framework

The *Creating Lasting Family Connections*[®] (CLFC) integrates an eclectic combination of personal, couple, family, and community strengthening theoretical frameworks. These frameworks are translated into a structured series of sequential, developmental, and experiential activities for participating families (youth and adult modules) and community members. CLFC incorporates Experiential Learning Theory (Kolb 1975) by providing an interactive program with a strategic mix of role plays, games, brainstorming, guided imagery, reflective exercises, demonstrations, and group discussions. Participants are invited to involve themselves in practicing or “experiencing” the ideas, concepts, and skills shared in the sessions and to engage in reflective thought and group discussion (Johnson 1997; Satir 1983).

Risk and Resiliency Theory (Hawkins et al. 1992) serves as a major underpinning of the program. Specific exercises are designed to build resiliency across the domains of self, family, school, and community (Benard 1991). Building from strengths, the program focuses on both intra- and inter-personal skill development including verbal and nonverbal communication (with an emphasis on listening and validation), how to say no (refusal skills), and family management practices to help prevent negative outcomes and mitigate known risk factors.

Further, CLFC combines Social Learning Theory (Bandura 1977) and Therapeutic Alliance (Bordin 1979) through the positive rapport established between staff and participants, and through staff modeling of appropriate relationship behaviors. Developing respected interpersonal connections is key in promoting growth in both

personal and family behavioral dynamics. For example, in the group “educational sessions” two program staff served in roles often perceived more as facilitators of information and role models of new possibilities rather than as “therapists.” A range of nonjudgmental, inclusive, and positive facilitation skills (Strader and Stuecker 2012) result in a Therapeutic Alliance between the CLFC trained facilitators and participants. This alliance can be carried into private case management sessions that, when needed, can lead to deeper personal work or other necessary referrals for more specific therapeutic interventions.

Key elements of Cognitive Behavioral Therapy (Beck 1993) are incorporated into group exercises. Participants are invited to participate in a process of individualized coaching and personal reflection in order to self-correct unhelpful thinking and behaviors. CLFC integrates this system of established theories which are expressed in the program design, exercises, activities, and implementation protocols. Each of these theories relates to the central belief described in *Building Healthy Individuals, Families and Communities* that “deep healthy connections build strong protective shields to prevent harm and to provide both nurturing and healing support” (Strader et al. 2000, p. 17). The book refers to this concept as “connect-immunity.”

Populations in Focus

The *Creating Lasting Family Connections*[®] (CLFC) Program was designed for at-risk Caucasian, African American, and Hispanic/Latino families (parents and youth) from urban, suburban, and rural areas in the USA. The program is implemented with universal, selective, and indicated populations as designated by the Institute of Medicine (IOM) Classification System.

Strategies and Techniques Used in Model

The *Creating Lasting Family Connections*[®] (CLFC) Program incorporates a rich variety of

strategies and techniques to appeal to the full range of adult and youth learning styles, cultural differences, personalities, and preferences. Learning strategies and techniques include brief lectures, role plays, guided imagery, reflections, discussions, brainstorming, facilitator demonstrations, storytelling, and interactive games. CLFC facilitators are trained and certified to implement the program. CLFC provides facilitators of differing gender, age, race, and experience to relate to the largest number of participants. CLFC facilitators role model the skills of the *CLFC Program*, therefore providing information within a relational and nonjudgmental context. Facilitators listen and validate participant thoughts and feelings, provide clear and sensitive feedback, and express their own emotions as a means to manage group participation and interaction throughout the program sessions. The concept of “influence versus control” is threaded throughout the entire *CLFC Program*. Facilitators both role model and manage the program under the belief that participants learn best when they can voluntarily choose their own preferred level of participation (i.e., active discussion, interactive practice, quiet listening, etc.) for each activity in each program session. Throughout the *CLFC Program*, facilitators incorporate motivational interviewing and trauma-informed care techniques into interactions with participants (Strader and Stuecker 2012). Culturally sensitive case management and ongoing support supplements the program content. Facilitators refer participants to appropriate service providers, as needed.

Research About the Model

In a large-scale study, the *Creating Lasting Family Connections*[®] (*CLFC Program*) was implemented in five communities in the Louisville, KY, area (Johnson et al. 1998). A community was defined as a group of people who form a support system based on shared activities and interests. Families were randomly assigned to the intervention group or control group. Participants were 183 high-risk youths, aged 12 through 14, and their families (95 in the

intervention group and 88 in the control group). Over half (58%) of the youths were female, with 16% of families identifying as African American. Almost half (47%) had five or more family members, and 30% were in low-to-medium-income groups. There were no statistically significant between-group baseline differences on key family and environmental characteristics (e.g., age, gender, youth access to marijuana, parent smoking behavior, and family participation in other alcohol and other drug programs).

Data on youth and family resilience and AOD use outcomes were collected before program initiation, after program services, and 1 year after program initiation. Parents in the intervention group reported statistically significant gains in knowledge about AOD and enhanced beliefs against using these substances, compared with parents in the control group (Johnson et al. 1995, 1998). Both parents and youths in the intervention group reported a statistically significant increase in use of community services to help deal with personal or family problems, compared with parents and youths in the control group (Johnson et al. 1995, 1998). The evaluation also found positive moderating effects on delayed onset and frequency of AOD use among youth.

Case Example

Doris (fictitious name used to protect her true identity), a single mother with five children, participated in the CLFC Program. During the initial Screening and Program Placement Survey meeting, she reported that she engaged in the program because the children’s fathers were “alcoholics and drug addicts” who had abandoned her and the children. She was frustrated with her constant need to “threaten, spank, and argue with her children.” She particularly wanted to “prevent her male children from turning out like their fathers.” She and three of her children participated in the program.

Early in the Raising Resilient Youth module, Doris participated in an exercise to reflect on how her own upbringing might have affected her approach to childrearing. Along with discovering

that her parents were not able to meet all of her needs as a child, she further became aware of how she was relying heavily on a series of “power and threat” techniques that were unintentionally triggering defensiveness and rebellion in her children. In another training room, her children were making their own discoveries about kind and compassionate relationships and developing empathy for their mother in the corresponding Developing Independence and Responsibility module. Next, Doris learned and practiced skills of listening and validating her children’s feelings, while establishing clear, fair, and consistent expectations and consequences. While she struggled with expectations and consequences, she also responded to the interactive experience of the Getting Real module. Doris volunteered to receive personal coaching during role plays on integrating her thoughts, feelings, and verbal and nonverbal language. With a little practice, Doris began providing more clear and compassionate messages to others, including her children. Her children were practicing similar communication skills of trust, empathy, and saying “no” to others regarding negative behaviors like alcohol and drug use while learning to show respect for the other person in the role play. In the alcohol and other drugs module, Doris realized how deeply and pervasively her father’s alcoholism had affected her and her family. As Doris recognized alcoholism as a disease (rather than her father’s choice to abandon her), she expressed feelings of understanding and forgiveness toward her father. She also recognized how her relationship with her father affected the choices she made for romantic partners. She expressed openness and excitement for the possibility of bringing healing to herself and her children. As her children participated in the youth version of the alcohol and drug module, two of her children expressed recognition of how they played certain roles in the family. The oldest child recognized that he alternated between playing a “hero” role when he did well and a “scapegoat” role when he made mistakes. A second child recognized how she played the “mascot” role by using humor to deflect attention from the family pain. Both of these children seemed to particularly benefit from learning to

express their emotions and from the closeness they felt with their mother when she could validate them. The children made a connection that not all hurtful situations needed to turn into angry interactions. This reduced blame and fighting in the family.

A year after participating in the program and several case management sessions, she and her children reported less angry and disrespectful behavior in the family and more communication and support. Both Doris and her children were beginning to listen and validate each other more and argue less. Doris stated with pride and satisfaction that her children really improved attendance at school and she reported less family conflict, less school problems, and greater success in schoolwork. She said that her children appeared to have less interest in alcohol and other drugs. She reported that she thought the entire program was very interesting and very helpful. She added that it was really hard to be good at everything she learned in the classes. Because of the family’s new way of thinking and talking about alcohol, other drugs, and emotions, Doris said she could see her children doing better and that is what mattered most.

Cross-References

- ▶ [Creating Lasting Family Connections Fatherhood Program: Family Reintegration \(CLFCFP\)](#)
- ▶ [Creating Lasting Family Connections Marriage Enhancement Program \(CLFCMEP\)](#)

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