

## Creating Internships in Marriage and Family Therapy: A Collaboration Between a Training Program and an Offender Reentry Facility

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**Abstract** The literature on clinical internships in marriage and family therapy is limited in the discussion of the development of clinical sites as well as the benefits and challenges experienced by students and programs. This article focuses on the development of a marriage and family therapy internship in an offender reentry facility. The process of how students are referred and trained, the rewards and challenges of their work, and the supervision experience are described. The purpose is to inform marriage and family therapy programs about a potential resource for training students.

**Keywords** Internship · Incarceration · Training program

The development and management of clinical settings for students is a significant part of marriage and family therapy (MFT) training programs. Although the MFT literature has some discussion of student experiences in clinical settings as part of their academic program (e.g., Brucker et al. 2005) the larger literature, including social work, counseling, and psychology, is more developed (Gawinski et al. 1999). MFT training experiences are unique in that they require specific supervisors trained in systemic approaches and require sites that allow students to see couples and families in addition to individuals. For this reason, more discussion and research focused on clinical training in MFT is needed.

### Marriage and Family Therapy Internships

Several challenges have been identified in developing and maintaining internships for MFT training programs (Ivey and Wampler 2000). These include little availability of sites where

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family therapy is a focus, few supervisors trained in systemic principles, high demands on faculty, and limited information available on how these issues are addressed.

The literature on the specific nature of MFT internships is scarce. A keyword search, in PsycInfo, using “family therapy” and “internship” identified 10 articles on the topic of MFT internships. Four of the articles addressed internship experiences of doctoral programs in MFT and five discussed internships in medical family therapy. Gawinski et al. (1999) described the experiences of doctoral interns and their supervisors in a multidisciplinary healthcare setting. Muchnick et al. (1993) focused on the experiences of interns in a collaborative internship between interns and physicians at a healthcare site. Grauf-Grounds and Sellers (2006) described the development of a postgraduate certificate specializing in medical family therapy, including the courses necessary as well as the dynamics of a specialized internship.

Williams (1994) writes about his experiences of the key factors in a successful MFT internship. These include frequent supervision with regular feedback from supervisees, the importance of the fit between the skills the intern wants to develop and the population typically served at the site, and the level and quality of socialization at a site. Williams (1994) also discusses the difficulties in finding an appropriate internship. Hamel and Laraway (2004) discussed an MFT internship in their program. They explained how dealing with no-shows was difficult for them as interns, also noting the value of different perspectives from multiple supervisors.

The current discussion focuses on a collaboration between an MFT graduate program and an offender reentry and in-prison treatment program. We discuss the process of how students are identified by the clinical coordinator for the site, how the site coordinator screens students for placement, experiences of the students at the site, supervision, and strengths and challenges of this collaboration.

### **Marriage and Family Therapy in an Incarceration Setting**

The impact of incarceration on individuals and their relationships is pervasive. Incarceration can erode relationship quality (Hairston 2001) and increase depression and suicidal ideation in an incarcerated person (Carlson and Cervera 1991). Nonincarcerated partners can experience feelings of shame and anger and often are less willing to compromise during disagreements and more likely to be violent when angry and to abuse alcohol and drugs (Western et al. 2004). Often, the wife is the partner left alone with increased responsibilities for child rearing and income earning (Accordino and Guerney 1998). The interactions, sexual intimacy, and time spent together are restricted because of the separation, the long travel times to correctional facilities, and the cost of collect calls (McMurray 1993).

Several studies have shown that both male and female inmates who maintain strong family ties are better able to cope while in prison, have fewer disciplinary problems while incarcerated, and are less likely to recidivate after release from prison (Bales and Mears 2008; Kemp et al. 1992; Lanier 1993). The interviews with inmates by Visher et al. (2004) revealed that connections to significant relationships maintained during the period of incarceration can be an important resource in helping released prisoners reduce recidivism. Similarly, Visher and Courtney (2006) found that families were an important source of emotional and family support after release, with 78% of former prisoners receiving support from families and 80% living with a relative. Family conflict can have the opposite effect. Some studies have shown that conflict with family members can hurt the reentry process.

Zamble and Quinsey (1997) found that conflict with a partner was the second most common influence on recidivism.

Gender differences in factors associated with ease of transition back into the community also have been reported. Married men who described their marriages as satisfying experienced more successful transitions to the community than those who described their marriages as unsatisfying (Fishman 1986). With regard to women offenders, Dowden and Andrews (1999) conducted a meta-analysis showing that interpersonal variables, such as self reported degree of affection in relationships, were the strongest predictors of female offenders' successful rehabilitation.

Children are also victims of incarcerated men and women. Over half of all prisoners have children (Bureau of Justice Statistics 2008). A difference between mothers and fathers is that 65% of mothers reported their children were cared for by another relative, usually a grandparent, while 84% of fathers reported the mother of their child was caring for their child. Incarcerated mothers report being worried for their child's safety, including fears of childhood sexual and physical abuse (Weilerstein 1995). Guilt is a common feeling among parents and there is great fear that their children will end up in the system because of them (Bloom and Steinhart 1993).

Children can have emotional and behavioral reactions to their parent's absence (Clark 1995), including aggression, poor school performance, attention deficit disorder, and sleep disturbances (Johnston 1995). These difficulties have been suggested to be more related to how the family deals with the separation, rather than to the trauma of the separation (Hannon et al. 1984).

MFT seems to be making some progress in improving marital and family satisfaction in prison settings (Gendreau 1996). At the most promising level, initial research has indicated that the mere visitation by family members and people with close ties to a prisoner can delay and even reduce recidivism (Bales and Mears 2008). On a more formal level, parenting education programs are one form of intervention that has gained popularity and been shown to be effective in incarceration settings (Harrison 1997). Indeed, research has demonstrated that parenting education can have an impact on parenting attitudes in incarcerated individuals (Palusci et al. 2008). Einhorn et al. (2008) implemented a marital education program, the Prevention and Relationship Enhancement Program, with prisoners in Oklahoma that was designed to prevent marital distress and divorce by teaching skills and principles to couples to maintain healthy and lasting relationships. Their findings showed that the program improved relationship satisfaction and marital communication within the sample. However, despite the increase in education programs on marital relationships and parenting, clinical family intervention programs that focus on relationship enhancement and family stability are rarely implemented in correctional facilities.

### **The Training Program**

Seton Hall University currently has accredited masters and post masters MFT degrees. The masters program typically takes 3 years to complete and students are required to accumulate 500 hours of client contact, half of which are with couples or families. The supervisor must provide at least 100 hours of supervision, half of those live or using video. The supervisor also must meet predetermined qualifications, such as being an AAMFT Approved Supervisor or the equivalent. The site must have the opportunity for students to see couples and families at a rate that would allow a student to complete the program in 3 years. Students begin clinical placement at the beginning of the program. Placement

typically begins with orientation to the site and observing intakes and other clinicians' sessions. Students then increase their caseload as they advance in the program at the discretion of the supervisor and in consideration of the comfort level of the student.

### **The Site**

The training program has been collaborating for approximately 12 years with Community Education Centers (CEC), a private correctional treatment company that partners with public entities. CEC is a reentry site that provides a full range of therapeutic residential and non-residential reentry services. Residents are primarily at CEC for property offenses (e.g., burglary, auto theft, fraud) and drug offenses (e.g., possession, intent to sell). Most have a history of multiple offenses, and approximately 70–80% have a history of substance abuse. CEC has a strong history of reducing recidivism. The national reincarceration rate is 2.1 times higher than CEC's (51.8 vs. 25%) at 3 years post-release (Fretz 2006).

In a cooperative effort between Seton Hall University and CEC, a program has been developed that addresses the multiple stressors facing families who have an incarcerated loved one. Under the direction of the site supervisor, who is a licensed MFT, psychologist, alcohol and drug counselor, and an AAMFT approved supervisor, students provide couple and family therapy to residents and their families. Students are placed at one of six sites in New Jersey where offenders, referred to as "residents," are awaiting release from incarceration. Under supervision, MFT students conduct genogram assessments, provide couple and family therapy, facilitate multi-family groups, and conduct Safe Family Groups for female residents who have experienced the co-occurrence of post-traumatic stress disorder (PTSD) and addiction. In an attempt to reduce the trauma of incarceration, the rituals that hold families together, such as celebrations of Christmas, Kwanzaa, Thanksgiving, Mother's Day, and Father's Day, are maintained.

Two of CEC's six offender reentry sites service women and men, but female students are able to work only with the female residents. This is one of the determining factors in the placement of a student.

### **Development of the Relationship**

Before the relationship with Seton Hall University began, CEC and their Family Services Director (FSD) realized the value of the family services that were being provided to residents. The facility started with one program, which was a family night. The FSD believed family night was a strong first step but that more intensive couple and family therapy was needed. The FSD knew if CEC wanted to expand to providing family therapy they had to use interns since there was not enough money in the budget to provide therapy otherwise. The FSD called program faculty at Seton Hall University to find out about interest in developing an MFT internship at CEC. There was interest and the details of the internship were worked out at the time. There was extensive discussion of how many students could be accommodated, supervisor credentials, safety issues, needs of the program in training students, and needs of the residents and their families at the site. With each additional student came the possibility of new programs, such as family groups. As CEC expanded to other locations the model was replicated with additional students.

## Clinical Experience

The clinical experience is multifaceted and involves cooperation and clear communication between the university and the site. Descriptions of the screening process, the different components of family therapy, the supervision, and monitoring of the student's progress follow. The discussions are grounded in the feedback of students, residents, and their families. The program and internship experience have been modified over time based on this feedback.

### Program Selection Process

Students are connected with a clinical site within their first semester of study. The clinical coordinator meets with all incoming students to determine their experience, strengths, and readiness. If a student is interested in the reentry setting, several questions are asked. Some examples include: Does the student have a desire to work with this population?; Does the student understand that he or she will be working with people who have been arrested and are now imprisoned in a secure setting? If a student is agreeable to these conditions, he or she is referred to the site for further screening and introduction to the site. Students often see many advantages to working in this setting. This includes little restriction on when they can see clients (many students like the idea that they can see families on weekends, especially if they are working during the week). This flexibility along with the residents' demand for family services allows for a quick accumulation of hours.

### Coordination Between Program and Site

If the clinical coordinator of the program deems a student appropriate for placement at the site, he contacts the family services director (FSD), who is also an LMFT and an AAMFT Approved Supervisor. This person has been running the family program for 11 years. The coordinator and the FSD discuss the appropriateness of the student, and if there is agreement on placement the student is told to schedule an interview with the FSD. During the interview the FSD explains the history of the site, the history of the connection with the training program, positives and negatives of working with this population, and the FSD's qualifications. The FSD also ascertains the student's level of experience, which informs the decision about the location to which the student will be referred.

Prior to beginning their clinical work, students must complete a criminal background check and drug screen. Each student receives a handbook and completes an orientation. The orientation provides special training on resident behaviors, particularly criminal thinking. Special emphasis is also placed on safety and security procedures. This includes highlighting that students should sit by the door and that there is a special code they can dial on the phone to get help. Training and information is given on sexuality and sexual boundaries. Residents will sometimes push boundaries with students, for example, by asking a student questions such as, "What is your marital status or where do you live?" This could be because the resident is attempting to manipulate the student or because therapy is foreign to him or her, as many residents have not been in therapy previously. Students are prepped on their responses and are advised to keep self disclosure to a minimum. One strategy is for the student to put the focus back on the resident.

At each facility a site visit is scheduled with the family services coordinator who runs the family program there. The coordinator walks through the facility with the student and explains the program at that particular site.

### Connection Between Residents and Family Treatment

Family intervention is introduced to the residents from the beginning of their stay at CEC. Residents complete a genogram at intake. Intake workers assess residents' families to determine which family members are available to support the lifestyle changes the residents need to make. Residents also are asked who may be involved in criminal and addictive behavior? Who is the resident going home to? Do people at home have addictive behaviors? If someone in a family is using drugs or alcohol, the site works to get the family member in for a visit to see if that person wants treatment from CEC and/or to be referred to services in his or her community. CEC focuses on co-dependency and enabling issues, along with typical relationship and family problems.

All residents are assigned a senior counselor who meets with them regularly and provides case management. After the intake, the genogram goes to the senior counselor who introduces the idea of family therapy to residents during their initial meetings. All residents are asked if they wish to participate in family therapy. The family services coordinator gets a list of those who want to be seen in family therapy. Residents also might engage in family therapy through attendance at family night. The demand is often so high that a waiting list is created.

Family involvement at CEC has two components. One, family night, is psychoeducational and geared towards large groups of residents and their families. The other is family therapy, which is provided by MFT students.

### Family Night

Family night was developed by the FSD as a response to the common challenges reported by families upon the incarcerated member's reentry. Every location within the reentry organization has family night. Once a week family members who have been approved for visits are invited to participate in psychoeducational groups, or family night. Family night occurs on a particular night of the week depending on the staffing availability. During the first part of the night, the family members and residents attend counselor-facilitated group sessions focused on the effects of incarceration on family dynamics as well as on the issues families will face upon reentry. MFT students are exposed to family night from the beginning of their internships. When a student has enough experience with family night, he or she is expected to help run the educational program. The second half of the night involves a family visit, during which residents and guests are provided an opportunity to employ the positive skills and behaviors gleaned from the program. The goal of family night is to encourage family and resident involvement within the context of a therapeutic climate. The following are examples of topics discussed weekly during family night: communication and problem solving, parenting skills, fathering, co-parenting, self-esteem, recovery for the family, life skills, thinking and distortions, forgiveness and healing, grief and loss, gaining control, alcohol, drug and emotional problems, boundaries, anger, adult children of alcoholics, addiction, and change.

Families often lack knowledge about the problems faced upon the reentry of residents into their communities and are unaware of the types of services that residents require upon release. It is important that family members and significant others are familiar with the concepts and information that the residents are receiving so that all parties may work together to promote a healthy lifestyle for the resident. Therefore, topics discussed at family night are designed to be integrated with the curriculum delivered to residents during

their daily treatment as reentry program participants. Family night is based on four cornerstones of family wellness: communication skills, problem solving skills, capacity for self-regulation, and forgiveness and healing of past hurts (Kissman and Torres 2004). Family night focuses on areas of “differentness” between family members, significant others, and residents in order to promote cooperative rather than conflictual relationships. For families, some of these areas include: money, extended family relationships, sex, recreation and friendship, work and career, child rearing, household responsibilities, and religious and spiritual growth. It is through examination of such issues and the development of the aforementioned cornerstones that residents and their loved ones can begin to build positive, pro-social relationships.

### Couple and Family Therapy

Family and/or couple therapy is available to all residents. The goals of these services are to incorporate the family into the resident’s reentry preparation and to assist in a process of reintegration into the couple/family system. Families can enhance the treatment process by being supportive and caring, or hinder a resident’s successful reentry by being emotionally non-supportive and distant. Therapy is usually once a week for 60 min. Family members are encouraged to participate in face-to-face sessions; however, phone sessions may be conducted as circumstances require. Therapy is often continued throughout the resident’s stay, although it may be terminated prematurely if treatment goals have been accomplished prior to the discharge date, the therapy is deemed counterproductive, or upon resident request.

Since most CEC residents live with partners, couples therapy is the most prevalent type of work conducted by interns. Couples therapy is centered on strengthening the couple relationship as well helping the couple with parenting skills. CEC focuses on bringing in family members that the residents will be living with when they return home so that residents and their families can be in the best position to prevent a return to their previous behaviors. Sometimes the resident will return to live with his or her parents and extended family and sessions are with those members. Residents are encouraged to bring children in for family sessions yet most residents prefer work to strengthen their relationship with their partner in preparation for returning home. Therapeutic groups, consisting of play and art therapy, are available to their children.

As a part of the academic program, students are exposed to a variety of models of MFT. They are encouraged to take parts of one or more models and develop their own model of understanding and intervening with families. They are able to work with couples and families at CEC and to discover which models fit with the student’s therapeutic style and beliefs about change. Students are not encouraged or discouraged from using any models by CEC administration or the FSD. They can utilize whichever model and interventions they choose. The FSD serves to help students develop a framework of change and at the same time develop an understanding of some of the common issues presented by residents, such as addiction, domestic violence, and criminal behavior.

Students have reported that a powerful part of the internship experience has been the freedom to create and run their own groups. They receive their initial training during a required group therapy class. Students are able to start specialty groups based on the needs of the population at the facility. Examples of groups have been men’s groups, women’s groups, codependency groups, and aftercare groups.

## A Complete Experience

Students often report that working with incarcerated individuals and their families brings both rewards and challenges. Students find that they grow in many ways during their internship experience at the site. The severity of the problems is intense and allows a student to develop a comprehensive and integrative model of MFT. The nature of the setting provides unique challenges that a student must work through in supervision. These benefits and challenges are discussed in the following sections.

### Benefits

There are many aspects of working with an incarcerated population that contribute to the learning experiences of students. A significant part of this work is the congruence between the mission of social justice inherent in the program, university, and organization, and the actual work taking place. Students are placed in a setting where they are able to make a difference in the lives of people who face many obstacles to meeting the basic needs of providing for their family, obtaining meaningful employment, gaining education, and seeing their children succeed. Students are able to provide a safe environment for residents to explore these challenges and make changes that can reduce some of the obstacles. One of the biggest ways students empower change is through the connection of family members and building of these relationships. Residents are faced with multiple strains in family relationships that leave them feeling disconnected and hopeless. Cutoff is a frequent way to manage anxious relationships and students are able to help residents repair relationships so they can be sources of strength and support as they re-enter their communities.

Though students are trained in criminal behavior and thinking, we recognize the risk of stereotyping clients before students see them. To prevent this, every effort is made by the FSD to balance information on criminal thinking with a focus on the humanity of residents. This is accomplished by having students discuss their biases about incarcerated people and how they might impact therapy. Students also are asked to highlight the positive patterns, behaviors, and areas of resilience in the lives of residents and their families.

For many of the residents, this is their first exposure to therapy. Students are able to witness many powerful parts of this process. Students are building a trusting relationship with residents with the goal of fostering hope and change. Couple and family therapy with the residents often leads to development of new insight into problems. Students are present with a family as they create meaning about family legacies, which may not have been discussed previously.

Students work with people of different backgrounds, belief systems, and presenting problems. Residents are diverse in their race and ethnic backgrounds as well as their socioeconomic status. Students are able to see the impact of poverty on a struggling family and recognize how lack of resources can exacerbate presenting problems. They are exposed to different worldviews on concepts such as relationships, marriage, and families. Students also are able to work with severe presenting issues such as physical, emotional, and sexual trauma, domestic violence, and addiction. Though interning in an incarcerated setting has many unique factors that distinguish it from an internship experience in a community mental health setting, the exposure to a diversity of people and presenting problems is similar. Students also gain experience in identifying circular causality and patterns within relationships.

## Challenges

Students begin by seeing residents alone so a student can understand the experience of incarceration. Then the work is broadened by inviting the resident's family members to join treatment. This can include significant others, parents, grandparents, siblings, and children. The student introduces the resident to therapy by explaining the counseling process. This includes how often they will meet and what could be worked on. Students are asked to obtain a statement of the problem. Many residents have not been in therapy before, so a clear statement of the problem is helpful. Usually, the resident introduces a problem that is immediate and task oriented, such as getting his or her partner to bring clothing. Though these problems are real issues faced by the residents, students try to balance the immediate needs with the larger issues such as parenting and communication.

One of the key factors in determining what therapy will look like is how long the resident will be at the facility. This time period determines whether therapy will be short term brief therapy or will involve more in-depth work. Sometimes students will be working against an upcoming release date, which leads to focusing on working through immediate issues with the family.

Individual characteristics of each resident can influence how therapy will progress. Some residents come in with little patience to struggle with developing insight into the history and development of their problems. In these cases, students will spend more time on concrete, solution focused work that focuses on how residents will address immediate issues facing them upon release. Other residents enter treatment curious about their family histories and previous traumas. They ask questions about their genograms and seem open to engaging in more in-depth treatment. This also can be influenced by time limitations. If a resident is scheduled to be released in the short term, the student is directed to spend more time on immediate needs rather than on in-depth work. One of the assumptions of CEC's family program is that positive exposure to therapy will make a resident more likely to engage in therapy when he or she leaves the facility. For many of the residents, this is the first time in therapy and a goal is to help them see the value of talking out their problems rather than acting out their problems.

A frequent challenge for students is that residents say they do not want to come back, but they do not have a plan to stay out. A common belief by a resident is "I just won't hang around with those people." A student can address this by providing education about the stressors and issues that can lead to relapse in addiction and criminal behavior. One of these issues is the residents' return to familiar communities, where they are faced with the same pulls to participate in criminal behavior. A helpful intervention is role playing situations that the resident may encounter on the outside. The role play is utilized to examine the complexity of being in risky situations. Students also have to help residents see the stress on the partner and family, since the partner is doing time simultaneously. A common struggle between a resident and his or her partner is what will be different when the resident gets out. Many of the residents have been in the criminal justice system before. Partners and family members begin to lose hope that anything will be different. Students help couples and families have discussions about this in a way that focuses on previously utilized strengths and resources.

Another factor that students must consider in their work is that the resident may not have seen his or her partner in a while. Maintaining focus on serious issues in the relationship can be difficult because the resident just wants some light, quality time with his or her partner. Some residents might choose to be in the therapy just to be with their partner rather than to work on any couple issues. This might be evident if they consistently want to

talk about other things besides any issues regarding their relationship. Therapy has to be stopped if the couple will not work towards specific goals. Couples do have the opportunity to spend some time together during family nights.

A common presenting problem for couples is past infidelity and the potential for current infidelity. Many of the men discuss trust, specifically infidelity, of their partners as a concern for them. Fidelity is also an issue for their partners on the outside. The concern of mostly female partners is that upon release, he will be unfaithful again.

### Supervision

Supervision is a necessary and invaluable part of managing the previously discussed challenges. Supervision takes place at least once a week and occurs in both group and individual settings. Both have advantages for the students. Group supervision is important as it allows students to learn from each other's experiences and deal with the unique issues of this population. Students are the only persons providing couple and family therapy services to residents and they are the only non-staff in the facility who interact with the residents. The FSD has observed that group supervision allows for bonding and support that keep students invested in this difficult work and more likely to remain at the site for their entire internship experience. Another advantage of group supervision is that advanced interns are able to share insight about their experiences with beginning interns. Interns are able to share some of their solutions to common barriers to change. Individual supervision allows for more time and attention to each student's videos and case reports. The FSD also can address any concerns about a student during individual supervision.

The FSD is the supervisor for all MFT students. At CEC, the FSD is also an advocate for the students' needs and an intermediary between administration and students. When students have difficulties or challenges at their site, they report the issue to the FSD, who then makes a decision about what course of action to take. The FSD begins to address an issue by challenging a student to apply his or her systemic training to the issue. Students are encouraged to handle issues on their own, if possible. If a student cannot manage the issue on his or her own, the FSD will work on behalf of the student. One example of this has been space issues. Occasionally, students have had difficulty obtaining space to see residents privately. The FSD has worked with administration to secure space when needed.

### Challenges of Supervision

#### *Finding Their Way*

One of the objectives of the academic program is for each student to develop a model of change. Students are exposed to many models of family therapy and are encouraged to discover how one understands the development of problems in families and how one thinks about intervening. Students also are encouraged to develop an integrative framework, utilizing concepts and techniques from many of the models.

This is a unique process at the site as students are faced with clients who have so many problems, and students may become confused about where to begin. The FSD does not focus on model development in the beginning of a student's experience but on being present with each family and trying to make sense of the problems that are being presented. Each resident is given a checklist at the beginning of his or her incarceration asking what areas are the most problematic. Issues on the list include money, communication,

addiction, parenting, and extended family. Students are encouraged to work with the residents and their families to identify one or two problems that would be the most helpful to focus on and would help them with their families upon release.

Students often are faced with two common presenting problems, addiction and criminal behavior. The FSD spends significant time during initial training with students on these two topics. Examples of this include teaching students to assess whether the resident will be returning home to someone who is an addict/codependent. Students are taught to determine whether they should intervene now, so that it is a sober environment when the resident returns home. There is also discussion of assessment and intervention in the patterns of interaction around substance use. Students learn to be sensitive to the use of manipulation to get one's way. Intervention is focused on helping a resident and his or her partner to see the needs of other family members. Many residents have never asked about their partner's needs.

Another factor in a student's movement toward a theory of family therapy is the developmental level of the student. If a student has some background in working with families and seems to have ease in joining with families and not becoming overwhelmed with multiple stressors, then theory development may start earlier.

### *Multiple Stressors*

One of the major challenges of supervision is the multiple problems of the residents who enter treatment. The issues each resident faces are numerous and multisystemic in nature. Students often feel overwhelmed by the magnitude of the problems faced by residents, which can include addiction, lack of employment, poor education, parenting issues, complaints about their partner, and often numerous legal charges. Residents have concerns about who will be at home when they return and whether there will be a sober environment. Residents also are faced with the difficulty of staying connected while being physically separated. Supervision must focus on helping a student to work on broadening the resident's view to include the impact of the separation on his or her partner and family. They also must spend time helping a couple negotiate issues related to finances and childrearing while the person is incarcerated.

### *Time Limitations*

Students are sometimes limited by the time restrictions of the reentry setting. If a student chooses to use a multigenerational model, the student can be restricted if the resident has limited time in the facility. They complete a genogram, but the ability to do in-depth, long term work with multiple generations is unlikely based on the circumstances of the resident's incarceration. The alternative way of viewing the time restrictions is that residents are confined to the facility, so they can process their sessions internally between meetings. Students also can process sessions and receive supervision and go to the following session with less chance of sabotage. At the same time, it can be a disadvantage in that residents and families cannot practice between sessions.

### *Belief Systems*

Students often are faced with how to deal with their own values when they conflict with those of a resident and his or her family. A common example is values about relationships.

Most students come into the setting with values that center on monogamous relationships grounded in marriage. Many of the residents have had multiple relationships and multiple children from those relationships. Another example is many students entering the facility see education as a central goal and aspiration for people. They feel conflicted when they hear expressions such as “going to jail is the cost of doing business.” They often are faced with a person in front of them who comes from a place where survival is the central focus.

To help students, the first step is putting all their biases on the table. Students must expose all their values so they can be acknowledged. This is also where the value of group supervision is apparent. Groups of students struggle together and challenge each other so they will not impose their value systems on the residents and their families. Another important supervision tool is discussing the resident as a person and connecting with his or her humanity. This process helps students look past their internal conflicts and focus on helping the person and his or her family. The resident and his or her family are often open to empathy and connection with the student. This helps the joining process and allows the student to be accepted as a part of the system.

## Conclusions

There is little discussion in the literature of internship experiences for students in masters degree programs in MFT. The clinical training experience in MFT is unique. When placing students, clinical coordinators need sites that have systemically trained supervisors and that allow students to have access to couples and families for clinical work. In the experience of the clinical coordinator in this discussion, this can be a challenging endeavor. This particular MFT program has had challenges finding sites with systemically trained supervisors who are willing to take students, as well as sites where family therapy is a focus of the agency.

The intent of this discussion was to show that prisons and similar facilities are potentially a rich area for family therapy training. The literature has documented the importance of family intervention while a resident is incarcerated and after. Family therapy internships can provide needed services to residents and their families.

The collaboration between CEC and Seton Hall has been a mutually beneficial relationship. Seton Hall students are able to provide valuable family services to residents and their families, and CEC is able to provide a place where family therapy training can happen. There are several challenges to the work but all of the challenges are able to be managed through clear communication between students and the FSD as well as between the FSD and the program’s clinical coordinator. Our hope is that other training programs and reentry facilities can create similar opportunities for students.

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