

A Specialty Clinic Model for Clinical Science Training: Translating Couples Research Into Practice in the Berkeley Couples Clinic

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Advances in family science have substantially changed the way marriage, couples, and family processes are studied. These advances have also transformed clinical practice and the training of new generations of scientists and clinicians. In this chapter, we explore changes in training using the clinical science program at the University of California, Berkeley, as a specific example of the interplay between scientific theory and research, on the one hand, and clinical training and practice, on the other.

In 1999, we embarked on developing a new model for providing practicum training for the graduate students in Berkeley's clinical science program. Not surprisingly, given our collective interests in marriage and other intimate relationships, our first effort was in the area of couples therapy. We offered the first specialty clinic for couples in fall 2000. Over the ensuing 5 years, we continued to offer the Couples Clinic while refining the training model. Along the way, several of our colleagues adopted the model and applied it to other clinical problems and treatments. In 2006, with the Berkeley program undertaking a thorough reexamination and updating of its curriculum, the specialty clinic model was adopted as "the" training model for all in-house practicum training. Developing this training model had a profound influence on our own thinking about and enjoyment of clinical training and clinical supervision, and had a similarly profound influence on our colleagues and on our students. In this chapter, we recount and reflect on these transformations and influences. But first, to provide some background and context, let us consider the way things were.

Of Boulders and Bowlers

When we were receiving our own clinical training, and later when we were training others, the predominant training model was the scientist–practitioner model. Officially endorsed by clinical psychology as the Boulder model (Raimy,

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1950), this model gave birth to a number of subsequent refinements leading most recently to the clinical science model (McFall, 1991). The Boulder model and its intellectual progeny all endorsed an intimate bidirectional relationship between science and practice in which clinical practice was grounded in science and clinical science was informed by practice. Unfortunately, these lofty ideals were often undermined by the most devilish of details.

In its canonical form, the scientist–practitioner model envisioned a tightly integrated, seamless blending of science and practice. But lurking behind this idealized unity was a far less integrated reality. Most scientist–practitioner programs were characterized by two parallel tracks: the science track, which was supervised by the academic faculty; and the practice track, which was supervised by the clinical faculty. The academic faculty had tenure-track university appointments, and their careers were largely devoted to basic research and scholarship. The clinical faculty were practicing clinicians in the community who supervised the clinical work of graduate students but were not involved in their research training. At Berkeley, the tracks were not totally separate. A long tradition of having the core academic faculty participate in clinical supervision enabled students to see the research faculty in clinical roles. But role integration remained elusive. Invariably, we found ourselves adopting a “two-hat” metaphor, speaking of wearing our “scientist hat” in the laboratory and our “clinician hat” in the Psychology Clinic. It is not surprising that our students also began thinking and speaking of themselves using similar metaphors.

Wearing multiple hats, like having multiple selves, may be an inevitable byproduct of living complex professional lives in complex university environments. However, in clinical psychology, the hats represented different paradigms with wholly different epistemologies. When donning the scientist hat, our assertions were typically based on tested theory and empirical evidence. When donning the clinician hat, our assertions were often based on untested theory and accumulated clinical experience. The discomfort resulting from the two-hat problem in clinical training was certainly not new. Many years earlier, Meehl (1973) made similar observations when explaining why he stopped attending case conferences (e.g., in his view, critical scientific thinking was often left at the door). We all shared painful memories of case conferences and other meetings in clinical programs in which behaviors and motivations of clients, trainees, and colleagues were confidently interpreted in terms of underlying pathologies and presumed traumatic life experiences, all based on clinical suppositions with little or no objective evidence.

The other side of this coin, often unfairly omitted from the discussion, is that in the design and interpretation of clinical research, critical clinical thinking was often absent from the discussion. The end result was ill-conceived, clinically naive studies that hampered the pace of discovery. Who knows how many dead ends reached in experimental psychopathology and how many treatments that have failed outside of the confines of the university clinic (e.g., Weisz, Donenberg, Han, & Weiss, 1995) could have been avoided if clinical scientists had spent a bit more time observing and working with patients and talking with clinicians before rushing to advance far-reaching theories of psychopathology and to launch exquisitely impractical manualized treatments?

In the Berkeley program, there were other disturbing symptoms of a schism between science and practice. Of particular note, there was no systematic col-

lection of objective outcome data for adult psychotherapy clients seen in the program's in-house Psychology Clinic. On two different occasions, quite modest proposals were made by the authors, once in the 1970s (P. A. Cowan) and once in the 1980s (R. W. Levenson), to have clients complete symptom inventories before and after treatment. These engendered a flurry of strong objections from the clinical faculty and from some of the academic faculty as well. It was asserted that data collection of this sort would interfere with the therapeutic process and would not be sensitive to the subtle changes that occur in therapy. After a full year of discussions in the 1980s, reasonable minds prevailed, and a modest evaluation program was established. The struggle to introduce even the most limited objective assessment into the ongoing work of Berkeley's Psychology Clinic served to illustrate just how separated science and practice had become in a training program that genuinely valued both. Similar experiences in other university clinics suggest that the Berkeley situation was by no means unique but rather representative of the kinds of struggles between academic and clinical faculty that were ongoing across the United States during the 1970s and 1980s (Weisz et al., 1995).

Empirically Supported Treatments: A Cure for All That Ails Clinical Science Training?

Our development of the specialty clinic training model occurred against the backdrop of increasing advocacy of empirically supported treatments (Chambless & Hollon, 1998). Thus, it was tempting to propose that practicum training in the Berkeley program should focus primarily on training our students to deliver these empirically supported treatments. There were, however, two strong arguments against this approach. First, there was ample evidence that master's-level therapists were just as effective in delivering those treatments as therapists with more advanced degrees (Christensen & Jacobson, 1994). Second, we were uncomfortable with the notion that the primary focus of clinical science training in a major research university was to prepare students to deliver already-designed and evaluated treatments. Rather, we envisioned doctoral-level clinical science students as more appropriately engaged in training that enabled them to develop and assess new treatments, refine existing treatments, and develop treatment delivery systems that were responsive to societal demands and financial realities, and informed by knowledge about dissemination and prevention. In our program at the time, only those few students who were working with faculty whose research was directly involved with treatment development, treatment evaluation, and prevention received any significant training in these important areas.

Evolution of a New Training Model

In an ideal world, we could have drawn inspiration for a new training model from the clinical training and clinical supervision we had received and given in the past. However, the three of us were trained in quite traditional Boulder model programs, and the Berkeley program also clearly reflected these values.

Thus, tweaking the existing training model was not a viable option. Instead, we came up with a set of design principles for a new model. The goals of this new training model would be to enable our students to (a) identify clinical problems where there was both a documented need for treatment and a real promise for applying existing scientific knowledge; (b) develop maximally efficient treatments that could be administered within the temporal and financial constraints of our university clinic and its clients; (c) design and implement treatment evaluations; (d) develop the procedures necessary to mount, maintain, and market these treatments; (e) disseminate our approaches and findings; and (f) wear the same hat in both the laboratory and the clinic.

The Specialty Clinic Training Model

The specialty clinical training model that we developed has now been applied to practicum training in a number of different areas at Berkeley. In our hands, it took the form of a Couples Clinic, which has now been offered five times. The three of us offered it together on three occasions. On the other two occasions, sabbaticals reduced our ranks, and thus one or two of us were joined by Dan Wile, a renowned couples therapist in the Berkeley area (Wile, 1993, 2002).

Each offering followed the same general format. During the first semester, there was a weekly 3-hour seminar devoted to reading the literature and planning the clinic. Once students actually began to see clients, the seminar was replaced by a weekly case conference and supervision. To the extent possible, each clinic “started from scratch.” This reflects a central goal of the model, which is to train clinical scientists who are comfortable with all phases of designing, implementing, delivering, and evaluating treatment programs. The training model contained nine key elements, which we discuss in the following sections.

Identifying the Target Problem

Each year’s clinic began with a consideration of what the focal problem and population would be. In the 1st year, partly based on the Cowans’ documentation of success with groups for new parents and parents of preschoolers (Cowan & Cowan, 1992), the group decided to recruit couples with young children. During the 2nd and 3rd years, the focus was broadened to include couples in distress who had not yet approached a therapist for help. Thus, this was a more traditional couples therapy with an earlier-than-usual preventive focus. In the 4th year, reflecting Levenson’s research on frontotemporal lobar degeneration and Alzheimer’s (Levenson & Miller, 2007), we focused on older couples who were dealing with a partner with dementia. Finally, in the 5th year, we focused on couples with a partner who had been diagnosed with prostate or breast cancer. These last two specialty clinics represented problem areas for intimate relationships for which mental health services for couples were not widely available.

Not knowing ahead of time where the discussions would lead or exactly what the clinic’s focus for that year would be produced some anxiety—both for us and for the students. Despite this initial discomfort, the process of selecting

a target problem turned out to be a fascinating and valuable training experience. As the specialty clinic training model has become more institutionalized in the Berkeley program, some clinics have specified the target problem ahead of time, which has facilitated student and faculty planning. Although clearly there is some loss associated with short-circuiting this aspect of the process, all indications are that the predesigned clinics have worked well.

Designing the Curriculum

With the target problem identified, we posed the question, “What do we need to know to be able to create an intervention for this problem?” The group then generated a list of useful topics, resources, and experts. This list was honed, edited, sequenced, and prioritized, yielding a week-by-week “syllabus” for the seminar. The goal was to discover what was already known about the target problem and its treatment—through readings, viewing videos, and consulting with experts. In this effort, we always started with the basic science related to the target problem and then worked toward promising intervention approaches and, if available, empirically supported treatments. Thus, for example, in our couples’ clinics, we started with the basic science of foundational issues such as attachment, emotion regulation, and conflict resolution before considering couple-focused interventions. Typically, responsibility for identifying the critical readings and resources for each topic and for leading each associated seminar session was divided among the group members.

Each year, our survey of the couples’ research and therapy literatures reinforced our initial impression that there was almost complete separation between them. Although all theories of couples therapy focus on a limited set of problems in couple relationships (e.g., communication), there has been little attempt by therapists to draw on research findings that delineate possible sources of relationship problems, address known risks associated with couples’ distress, and target buffering factors that could protect couples when difficult problems arise. By the same token, couples researchers have made few attempts to use intervention results to validate their causal theories about mechanisms that foment or buffer against dysfunctional family patterns.

Establishing the Timeline

In academia, research and clinical projects can easily expand to fill all available hours, and therefore it is often too easy to forgo undertaking projects because “there simply is not enough time.” Learning how to work efficiently within a fixed and limited time schedule was an important part of the specialty clinic training. Once the target problem was identified and the process of designing the curriculum was underway, the group established deadlines for completing the various tasks that were necessary before the intervention could begin. This involved selecting the target start date for seeing clients and working backward to determine which prior tasks needed to be completed and by when. Compressing the training, preparation, intervention, and evaluation into a 9-month academic timetable was initially daunting. A successful

solution required additional prioritizing, planning, and efficiencies, all skills that proved to be extremely useful in launching the Couples Clinics and that should serve our trainees well in later clinical and research endeavors.

Designing the Intervention: The “Toolbox”

With our foundational belief that doctoral students in clinical science are best served by learning how to develop, deliver, and evaluate treatments, our specialty clinics gravitated toward target problems for which empirically supported treatments and off-the-shelf treatment manuals were not available. Thus, the process of designing the intervention became one of transforming scientific knowledge about a problem into a form that could be used with clients. To facilitate this, we adopted a “toolbox” metaphor, in which the group developed modular exercises, activities, topics, and experiences that were based on empirical findings. For example, for a couples intervention, modules were developed around attachment styles, emotion regulation, and empathic understanding, all of which had been associated with marital distress in the empirical literature. Modules could be psychoeducational, experiential, or observational. The modules in the toolbox were available for use in a planned way (e.g., in a particular session, all couples made and discussed a video recording of a conflictive interaction) or as needed (e.g., a module on sexual intimacy was introduced for a couple if the issue came up in a session). We found that having these modules on hand helped therapists feel more comfortable when working in areas in which they did not have much prior experience.

By building modules around scientific findings, we ran the risk of confounding correlation with causation. For example, a correlation between a certain family of negative emotions and relationship distress (Gottman & Levenson, 1992) does not mean that an intervention that reduces expression of those emotions will lead to an improvement in relationship satisfaction. That is an empirical question that needs to be evaluated within an appropriate intervention study. Nevertheless, the specialty clinic model rests on the assumption that such well-established correlations derived from the scientific literature form a sound basis for designing interventions. This is particularly critical in areas in which there is no empirically supported treatment, thus begging the question, “Where do we start?” For us, the answer to that question was always to start with the basic science related to this problem.

Some of the specific tools that were developed may be informative. From a well-established couples research paradigm (Levenson & Gottman, 1983), we developed the Video Problem Discussion. In the second or third session, with the couples’ permission, a video recorder was introduced into the session. The therapist worked with the couple to identify an unresolved problem between them that elicited high levels of conflict and then asked them to spend 10 minutes attempting to make progress on the issue. The videotape was then replayed, and the partners were asked to stop the action whenever one of them noted something that he or she wanted to discuss. Many partners suddenly “saw” verbal or nonverbal behaviors that they were completely unaware of but that they now realized were contributing to the negative atmosphere of their discussions. This rich material facilitated the therapeutic work.

Another tool was the Family Album, which was designed to reaccess positive emotions, to reflect on earlier happy times, and to cue intergenerational relationships. Couples brought in their family albums or photos from their early days together. This exercise elicited forgotten memories of emotional connections and positive feelings from earlier in their relationship. These memories and feelings often fueled hopes of getting back to those more positive states.

Following this model, the student therapists also invented tools during the course of therapy to help couples communicate their feelings. In one particularly memorable tool, couples rolled different colored balls back and forth to represent positive and negative feelings they were having during the therapy.

Marketing the Intervention

Specialty clinics typically change from year to year; thus, unlike a regular clinic that has a longstanding reputation for “taking all comers,” it is critical to get the word out to those most likely to benefit. Training in marketing is normally not part of a clinical science curriculum. However, it is an enjoyable and challenging enterprise, in which feedback as to the success of the marketing plan comes rather quickly. In the current age, the ubiquity of the Internet is a major asset for advertising specialty clinics. Thus, part of each marketing plan was the design, production, and placement of notices that were suitable for online posting and identification of sites most likely to be read by potential clients. Referrals from professionals in the community were another valuable resource. Obtaining referrals usually required designing a letter, brochure, or card, plus some in-person or telephone contact. For example, when we were offering our specialty clinic for couples dealing with cancer, we contacted doctors in oncology practices, offered to meet with them to explain the clinic and its services, and followed up to give them feedback and encourage referrals of more patients. When we were offering our specialty clinic for couples dealing with dementia, we contacted local dementia clinics and caregiver support groups. The marketing phase was invariably iterative, with rapid modification of the recruiting plan if initial attempts were not successful.

Designing the Evaluation

Another foundational belief of the specialty clinic model was that intervention and evaluation are inextricably linked. For that reason, we engaged the group actively in planning an assessment that would help us learn whether the intervention was successful. By encouraging the group to include preintervention/postintervention, weekly “thermometer ratings,” and follow-up measures, the students gained experience with some of the major approaches to treatment assessment. To assist in this process, the group members devoted seminar time to readings and discussions relevant to this topic.

The process of designing the evaluation was an exercise in balancing the ideal against the possible. A full-scale randomized clinical trial is, of course, typically not possible within the constraints of the specialty clinic. This led to useful discussions about the advantages of some evaluation over none. Invariably, the

initial assessment battery that was compiled was far too large to be practical, and inevitably, the less-is-more approach won out. The decision process provided the group with a valuable experience in prioritizing, pruning, and focusing. Evaluating existing measures was an important part of the process, as was designing new items and new measures when no suitable ones existed (e.g., adding items to relationship questionnaires that addressed the effects of dementia or cancer for those specialty clinics).

The evaluation package selected for the first Couples Clinic for couples with young children is illustrative. The pretreatment and posttreatment package completed by each partner included measures of relationship satisfaction and quality, division of household and child-care tasks, belief in partners' capacity to change, communication quality, psychological and physical symptoms, and life stress. This battery of instruments met our design goals of covering the key dimensions of individual and couple functioning targeted by the therapy and taking approximately 30 minutes to complete. In retrospect, including a measure of attachment security would have been useful.

In addition to the pre-post assessments, we included weekly "thermometer" ratings filled out before the therapy hour in which partners indicated how they perceived their relationship as a couple and how they perceived the therapy. Some of the therapists used this information to raise important issues with their couples during the sessions. In our end-of-clinic evaluation of treatment efficacy, these weekly ratings proved useful in assessing the impact of particular interventions and well as patterns of change over time.

Designing the Clinic Procedures

A specialty clinic requires establishing procedures for handling phone calls and inquiries, case assignment, fee setting and collection, scheduling sessions, session notes, final summaries, and a host of other details. Housing our specialty clinics within the general Psychology Clinic at Berkeley enabled us to make use of the clinic's facilities and staff, but each specialty clinic's procedures needed to be carefully integrated into the clinic's existing procedures. This required developing and providing various forms and assessment materials, carefully briefing Psychology Clinic staff, and maintaining quality control over the course of the specialty clinic.

Supervision

As mentioned earlier, we structured clinic supervision initially as a group case conference. Based on students' feedback, we later modified the plan so that there was 1 hour of group supervision each week and an additional half-hour per case of individual supervision or cosupervision if the students were acting as cotherapists.

Audio or video recordings were made of all therapy sessions, which we made heavy use of in supervision. In the group case conference, cases were discussed that illustrated interesting problems, solutions, and principles. In these discussions, we made reference whenever possible to the relevant research literature

and theoretical concepts. When appropriate, the group worked to develop new tools, which were then added to the communal toolbox. The individual supervisions allowed us to monitor each case on a weekly basis and to provide support for each of the therapists, including addressing their strengths and vulnerabilities in a setting that was more private than the group case conference.

Assessing the Efficacy of the Treatment

Once the clinic ended, it was essential to collate and analyze the data that were collected to evaluate the efficacy of the treatment. Typically, these data were not available until the very end of the semester, when the group had already disbanded or would soon do so. One of the ways we found to ensure that these data did get processed and evaluated was to devote a colloquium session in the following fall to a presentation on the previous year's specialty clinic. This presentation described the targeted problem, the intervention and evaluation that were designed, and the findings. This also helped to disseminate the work of the specialty clinic to the rest of the clinical science program's students and faculty. Now, with all in-house clinical training in the Berkeley program following the specialty clinic model, we plan to institutionalize this process, with a colloquium or two scheduled each year devoted to presentations from all of the previous year's specialty clinics.

The findings from the first Couples Clinic were illustrative. Twelve couples were seen, and all completed the assessment battery before and after treatment. Overall, we found a number of statistically significant positive changes, more for female partners than for male partners. The changes for female partners included increased relationship satisfaction, increased satisfaction with couple communication (most markedly, increased comfort with the expression of feelings within the relationship), and reduction of physical symptoms. We found that increased comfort with emotion in the relationship was highly correlated with female partners' increases in marital satisfaction (R^2 change = .61, $p < .02$). The only significant change for male partners was reduced perceived life stress. Neither partner showed significant change in general psychological symptoms (e.g., depression, anxiety), suggesting some specificity of the treatment effects. Weekly relationship satisfaction ratings showed considerable variability over time, with a significant upward shift toward the last two therapy sessions. Satisfaction with therapy showed a gradual upward trend for both men and women. We also used the weekly ratings to evaluate the impact of the video feedback tool. In the week following the review of the videotaped conflict discussion, male partners' relationship satisfaction increased significantly but female partners' did not.

These findings, with interesting sex differences, support for the specificity of the treatment, a relationship between comfort with emotion and relationship satisfaction change, and the positive impact of the video feedback tool, were illustrative of the kinds of rich information that can be obtained from even a modest evaluation. All of the findings stimulated interesting and valuable discussion both within the specialty clinic and among other members of the clinical science program, with many connections made to existing empirical and

theoretical literatures. This kind of discussion, in which treatment issues and data were presented and discussed in a forum and manner normally devoted to laboratory data, was highly transformative for the clinical science program.

Student Experiences

As the three of us set out to write this chapter, we asked alumni of the Couples Clinic to share their memories and reactions, the effects the experience had on them professionally and personally, and ways to make the experience more valuable. The reflections in the sections that follow were obtained 1 to 6 years after the experience, and many of the respondents had already begun their careers as researchers, teachers, therapists, and/or supervisors. Several began by saying that they had recently been thinking about their time in the Couples Clinic because they were working with couples as predoctoral or postdoctoral fellows or supervising students' couples cases.

Integration of Science and Practice

I remember the Couples Clinic fondly. Probably of all my graduate school experiences, it most impressed on me a model for integrating research with clinical practice. I was inspired by the manner in which the research literature on couples informed the development of new clinical practice, and then clinical experiences with the couples contributed to new research questions.

As I complete my postdoctoral training, I realize that my career goals have been shaped by the Couples Clinic. I would like to create an empirically based and evaluated couples and family program for trauma survivors. This program would be based on the premise that family relationships affect and are affected by individuals' responses to traumatic life events.

Seeing this model enacted by my professors at Berkeley probably contributed to my personal ability to visualize myself in an academic job; I learned that it was possible to integrate clinical work and research in academia. I aim to enact this model in my current program of research developing and testing interventions for friendship problems among youths with [attention-deficit/hyperactivity disorder]. Passing on this model to my graduate students is also integral to my teaching philosophy.

Impact on Therapeutic Skills

Perhaps the greatest benefit I received from working in the Couples Clinic is a true appreciation for the value of multiple perspectives on one problem—from the clients' and the clinicians' side. Therapists are often painted a picture by a client that is one-sided, and we, in turn, can construct an image that is seldom challenged. The Couples Clinic was a constant reminder of just how many different ways a single act or comment can be perceived.

My experience in the Couples Clinic affected my teaching too, as I realized how little most people really know about dementia and how much destruction it can cause for families. As a result of this experience, I think that I am better able to convey to students how devastating these diseases are and how little we still know about them.

My experience in the Couples Clinic was largely colored by an unexpected occurrence: the passing away of a client due to cancer. The work that my cotherapist and I did with this couple began as traditional couples counseling, transitioned to assisting the clients work through issues around the end of one partner's life, and finished with helping the surviving partner work through his grief and explore his goals for himself in the future. . . . To me, the fact that we were able to help these clients during such a difficult time speaks to why this profession is so important.

The Course Process

The thing that stands out the most about the Couples Clinic was the feeling that as students, we had some say in the development of the clinic, the direction of the theories we studied, and ideas about how we would apply those to the couples we worked with. This was only my 2nd year in the clinical graduate program. For the first time, I really felt that I was actively involved in the development of an intervention, working collaboratively with faculty and students at the same time.

Supervision

The supervision experience in the Couples Clinic stands out. In the 4 years of clinical work that I have conducted since then, I have not received such intensive supervision. . . . These were vulnerable and intense experiences to share with each other as trainees and definitely brought us closer together (we still refer back to some of the sessions that we did together 4 years later!).

The collaborative relationship with the faculty is something that stuck with me in my work as a clinical supervisor with beginning students. I have been trying to develop a collaborative relationship with my supervisees where they feel like they are integral in the design of clinical interventions, as opposed to my teaching a technique or an orientation per se. I use a number of "tools" that we discussed in the Couples Clinic with my clinical supervisees now, but the collaborative nature of the clinic was important to my development as a teacher and mentor.

Personal Influences

On a more personal note, my experience in the Couples Clinic was an enlightening tutorial on the power of "hurt." Being in the room with couples who carried scars from interpersonal injuries and insults from long ago, I could really appreciate the enormous efforts necessary to truly heal some relationship wounds. Now that I am married (and have accumulated and inflicted some hurts of my own), I have a renewed understanding of why it takes hard work to make a relationship last.

Closing Thoughts

We end this chapter with some reflections about this collaborative undertaking and about its effects on our students, the Berkeley clinical science program, and us.

Impact on the Students

It seems clear that our goal of bringing together the research and clinical literatures on couple relationships and blending them with experience in developing treatments to fit the particular problems of the couples we sought each year, all with intensive supervision, was daunting and eye opening for students. It is gratifying to us that it also propelled some of our trainees toward adopting some of this style of teaching, conducting treatment, and supervising in their own careers as clinical scientists. Reading their comments in our course evaluations over the years and in the retrospective comments we obtained for this chapter, we were extremely gratified that the students overwhelmingly felt that the integration of science and practice “worked,” that they felt competent to use this approach in their own professional lives, and that the quality of training was high in all domains.

Impact on the Berkeley Program

Our colleagues in Berkeley’s clinical science program have now adopted this model for all in-house clinical training, and it has been embraced by our clinical science students. These steps provide some indication that this single-hat approach fits others as well as it fit us.

Impact on Us

The specialty clinic model emerged from an amalgam of our own experiences as clinical psychologists, spanning the decades from our own training to our years as faculty members. Looking back, it reflects both the frustrations and the joys of these experiences, representing a final product that was designed to minimize the former and maximize the latter. There is no question that, compared with more traditional training models, the specialty clinic model requires much more time and effort, produces more anxiety, and requires constant assurance (of our students and ourselves) that everything will ultimately work out. With all of the demands and rewards of academic life stacked in favor of maximizing time devoted to pure research pursuits and minimizing time devoted to other endeavors, the question becomes whether taking on this kind of labor-intensive training is really worth it. For us (and we believe for our students), the answer has clearly been yes. Planning these clinics has been far and away among the most enjoyable teaching experiences of our careers. Moreover, the opportunity to merge our clinical and scientist roles into a single clinical science role has provided a remarkable antidote to the headaches usually involved in trying to wear two hats. Working with each other, with our colleague Dan Wile, and with our remarkable graduate students in this endeavor has expanded our understanding of couples and stimulated new ideas for research and intervention in ways that would not have occurred in more traditional one-supervisor/one-student/one-approach forms of clinical teaching.

We are hopeful that others who read this chapter will be inspired to try this model in their own clinical teaching. With full sensitivity to any and all signs of

incipient narcissism, we cannot help thinking that what has been so good for us might be equally good for others in the larger clinical science community. Perhaps the most telling sign of our own enthusiasm was that after the Cowans retired (the occasion for this volume), we all realized how much we missed offering the Couples Clinic together. And so we are now planning to offer one more specialty clinic together in the 2010–2011 academic year. Who says that the fun of teaching within this model has to end with retirement?

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