

Veteran Barriers to Mental Health

Kevin Cameron

Cameron Constructs, Sacramento, CA, USA

Email: drkevincameron@gmail.com

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Abstract

This study explores whether master's-level therapists and doctoral-level psychologists in California receive meaningfully different training for providing mental health care—and what that means for Veterans' access to treatment. Although psychologists are often preferred for Department of Veterans Affairs (VA) positions, both doctoral and master's programs require nearly identical coursework, clinical hours, and supervision. Using data from 32 APA-accredited doctoral programs, the research found that 28 programs (87.5%) award a master's degree in psychology after students complete their core clinical courses and practicum hours before finishing the dissertation. Both California licensing boards, the Board of Psychology (BOP) and the Board of Behavioral Sciences (BBS), require 3000 supervised clinical hours and define competence by training and experience, not by degree level. These findings indicate that the doctoral dissertation is an academic research project rather than a clinical training requirement. As a result, doctoral and master's graduates enter the field with equivalent preparation for therapy, assessment, and ethical practice. However, VA employment policies that limit many positions to doctoral-level clinicians restrict the available workforce and delay access to care. If qualified master's-level therapists were recognized as eligible providers, California's Veteran mental health workforce could expand by more than 60%, reducing appointment wait times and improving continuity of care. The study concludes that adopting competency-based licensure and hiring standards, rather than degree-based distinctions, may strengthen the mental-health system and better serve the needs of Veterans.

Keywords

Veteran, Military, Barriers, PTSD, VA, Universities

1. Introduction

California is home to approximately 1.6 million Veterans, the largest Veteran pop-

ulation in the United States (CalVet, 2024). Despite extensive state and federal investment in mental health resources, Veterans continue to experience significant barriers to timely access, particularly in rural regions. The U.S. Department of Veterans Affairs (2023a) reports that mental health provider vacancies remain above 25% in several California VA Medical Centers, resulting in an average 35-day wait time for behavioral health appointments. Expanding the pool of eligible therapists by recognizing master's-level clinicians with equivalent training could substantially alleviate this shortage and improve continuity of care across the Veteran population.

Access to timely, high-quality mental health care remains one of the most significant challenges facing the Veteran population in the United States. Veterans frequently experience elevated rates of depression, posttraumatic stress disorder (PTSD), substance use, and suicide compared to the general population. The Department of Veterans Affairs (VA) and affiliated community programs have worked to expand services, yet a chronic shortage of qualified mental health providers, particularly in rural and underserved areas, continues to limit care availability (U.S. Department of Veterans Affairs, 2023a).

One of the structural contributors to this shortage lies in the degree-based hierarchy within the mental health workforce. In California and many other states, licensed psychologists (Ph.D. or Psy.D.) are often prioritized for Veteran treatment roles, while master's-level clinicians—such as Licensed Marriage and Family Therapists (LMFTs) and Licensed Professional Clinical Counselors (LPCCs) are sometimes excluded from equivalent positions or reimbursement tiers, despite comparable clinical training.

This division persists even though the educational and clinical preparation required for these credentials often overlaps significantly. For example, both master's and doctoral-level therapists in California complete approximately 3000 hours of supervised clinical experience, cover nearly identical coursework in assessment, ethics, and treatment planning, and are evaluated according to comparable competency standards. The key distinction lies in the doctoral requirement of a research dissertation and differences in programmatic accreditation.

Although doctoral-level clinicians historically held primary responsibility for psychological assessment and treatment within the VA and similar systems, the current shortage of licensed psychologists has created an urgent need to reconsider whether this distinction is educationally justified. Many LMFTs and LPCCs possess equivalent training in trauma-informed therapy, family systems, and evidence-based interventions commonly used with Veterans (e.g., CBT, EMDR, ACT). However, licensing and employment policies frequently restrict their roles, perpetuating access gaps in critical services such as PTSD treatment, couples counseling, and community reintegration programs.

At the same time, recent literature has found no measurable difference in clinical competence or treatment effectiveness between master's-level and doctoral-level practitioners (Campbell, Worrell, & Dailey, 2018; Ozelie et al., 2020; Chabot

et al., 2024). In California, the Board of Psychology (BOP) and Board of Behavioral Sciences (BBS) maintain similar requirements for clinical training, supervision, and ethical competence, suggesting that licensure distinctions may reflect professional tradition rather than empirical necessity.

Therefore, the central problem this study addresses is the misalignment between degree-based credentialing systems and actual clinical competence, which may act as a barrier to expanding the mental health workforce serving Veterans. If educational and licensing standards are equivalent across degrees, policy reforms allowing broader utilization of LMFTs and LPCCs within Veteran-serving systems could significantly increase care accessibility.

The purpose of this study is to compare the educational and licensing standards of doctoral- and master's-level therapists in California through the lens of barriers to Veteran mental health care. Specifically, the research will examine APA-accredited doctoral programs and master's-level therapy degree programs in the state of California.

The study aims to determine whether substantive educational or competency differences exist between these training pathways and to assess whether those differences justify current distinctions in scope of practice or hiring preferences—particularly within Veteran-focused care systems such as the VA, Vet Centers, and community partner organizations.

The broader goal is to evaluate whether master's-level therapists possess equivalent educational preparation to serve Veteran populations effectively and to identify whether degree-based restrictions constitute an unnecessary barrier to care. This research asks: What are the similarities and differences in coursework, supervised training hours, and clinical competencies between doctoral- and master's-level programs? Could expanding recognition of master's-level therapists in Veteran-serving systems increase access to evidence-based care without compromising treatment quality?

The relevance of this research extends beyond academic inquiry into the realm of public health policy. The VA and community Veteran programs face a persistent shortage of licensed providers, leading to long wait times and limited access to psychotherapy, especially in rural and high-need regions. If this study demonstrates that master's-level therapists are educationally and clinically equivalent to their doctoral-level counterparts, its findings could support policy changes that expand the pool of eligible mental health providers for Veterans.

By analyzing accreditation standards, supervised hours, and licensing equivalency, this research contributes to evidence-based workforce policy and competency-based education reform. Furthermore, the study aligns with the VA's strategic priorities of improving mental health access, reducing suicide risk, and building an inclusive provider network. Demonstrating the equivalency of master's-level education could empower policymakers to implement licensure portability, reimbursement equality, and hiring flexibility within the Veteran mental health system, addressing one of the most urgent public health challenges of our

time.

This study seeks to explore whether the hierarchical distinction between doctoral and master's-level therapists in California is justified by genuine differences in educational preparation or whether it represents a systemic barrier to care for Veterans. By comparing the content, supervision, and competency requirements across different accreditation types, this research aims to inform policies that could expand the mental health workforce while maintaining professional integrity and clinical excellence.

2. Review of Related Literature

The mental-health workforce in California reflects diverse educational pathways—master's-level clinicians such as Marriage and Family Therapists (LMFTs) and Licensed Professional Clinical Counselors (LPCCs), and doctoral-level psychologists (Ph.D., Psy.D.). Despite differences in degree title, many programs share comparable curricula, practicum requirements, and supervised experience hours. The persistence of hierarchical licensure and reimbursement distinctions raises questions about whether doctoral training yields distinct competencies or outcomes that justify differential professional treatment.

This literature review evaluates empirical and policy-based research on educational content, accreditation, and licensing standards between APA-accredited, non-APA-accredited, and online psychology and counseling programs, particularly within California's regulatory context.

2.1. Accreditation and Professional Identity

Accreditation plays a central role in defining professional legitimacy in psychology. The American Psychological Association (APA) has long been regarded as the "gold standard" for clinical-psychology education. However, the APA's focus on research competence and scientist-practitioner training often contrasts with the applied, practitioner-scholar orientation of Psy.D. and counseling programs.

Campbell, Worrell, and Dailey (2018) reviewed the evolution of master's- and doctoral-level practice in psychology, concluding that APA accreditation primarily codifies administrative structure rather than guaranteeing superior therapeutic outcomes. They argued that professional differentiation often stems from historical prestige rather than empirical competency evidence.

Similarly, Lemez and Jimenez (2022) found minimal evidence that the move from master's- to doctoral-entry requirements in occupational therapy improved clinical readiness or patient outcomes. Their systematic review emphasized that educational inflation has outpaced evidence of corresponding gains in practitioner competence.

Non-APA Programs and California Licensure

California's Board of Psychology (BOP) allows graduates from regionally accredited but non-APA programs to seek licensure through a process of "substantial equivalency." This flexibility positions California as a useful case study in com-

petency-based regulation.

Programs such as National University, California Southern University, Pacifica Graduate Institute, Saybrook University, and Fielding Graduate University exemplify non-APA pathways that maintain WSCUC (2024) regional accreditation while aligning curricula with BOP standards. These programs typically require:

- 3000 supervised hours (1500 pre-doc + 1500 post-doc),
- coursework in 13 core content areas, and
- a doctoral project or dissertation.

Ozelie et al. (2020) evaluated a master's-to-doctorate transition in occupational therapy and found that curricular changes did not significantly alter licensing outcomes or perceived competence, reinforcing the notion that accreditation status alone does not determine practice readiness.

Chabot et al. (2024) likewise reported that while doctorate graduates expressed greater confidence in research and leadership, their clinical competencies were equivalent to those of master's-level practitioners.

Online and Hybrid Models

The expansion of online and hybrid delivery formats has blurred the boundary between traditional and distance training. Institutions such as Pepperdine University, Alliant International University, and Loma Linda University now offer online COAMFTE-accredited MFT or counseling programs that meet California's Board of Behavioral Science (BBS) requirements.

Contemporary studies (e.g., Godfrey, 2020) demonstrate that learning outcomes and licensure exam pass rates in online counseling programs are statistically comparable to campus-based programs when supervision and practicum standards are maintained. Thew and Harkness (2018) similarly found that supervision quality and mentorship, rather than delivery modality, predicted student success in clinical placements.

Educational Equivalency and Competency Benchmarks

Both the APA's Competency Benchmarks for Professional Psychology (APA, 2011) and the BBS licensure standards define professional readiness in terms of demonstrated competence, not degree level. California's BOP explicitly recognizes that "professional competence, not degree title, determines authorization to use psychological assessment and intervention tools" (California Code of Regulations §1387).

Campbell et al. (2018) and Muir (2016) observed that while doctoral programs emphasize scholarly research, clinical coursework, and practicum expectations mirror those of master's programs. This convergence challenges the assumption that a doctoral credential inherently ensures superior practice capability. It should be noted that APA programs enroll students with master's level degrees from non-APA accredited universities to engage in doctoral studies.

Policy and Access Implications

Empirical convergence of competencies supports re-evaluation of degree-based licensure hierarchies. California's flexible equivalency provisions already permit

qualified non-APA graduates to obtain licensure, suggesting that competency-based assessment can maintain professional standards while broadening workforce entry.

Reducing unnecessary educational barriers could mitigate therapist shortages and improve the affordability of care. As [Chabot et al. \(2024\)](#) and [Lemez and Jimenez \(2022\)](#) highlight, the lack of measurable performance differences between degree levels indicates that expanding licensure pathways for master's-trained or non-APA-trained clinicians could enhance access without compromising quality.

Professional Ethics and Competence

Both the APA Ethics Code ([APA, 2017](#)) and California BBS statutes (§4980.40) define professional practice boundaries according to competence, not degree level. Standard 2.01 of the APA Ethics Code explicitly states that psychologists should provide services only within the areas of their education, training, and supervised experience. Similarly, BBS guidelines extend the same principle to LMFTs and LPCCs. This ethical equivalence reinforces the central finding that competence, not credentials, is the legitimate basis for clinical authorization—an ethical foundation directly aligned with improving Veterans' access to qualified providers.

Conclusion

The post-2017 research landscape provides little evidence that APA-accredited doctoral programs produce more competent or effective clinicians than non-APA or master's-level programs meeting equivalent supervision and coursework standards. California's regulatory framework illustrates a pragmatic balance—requiring proof of competency and supervised experience rather than rigid accreditation status.

Future research should quantitatively compare licensure exam pass rates, supervision outcomes, and client-care metrics across these educational tiers. Until then, the available literature supports the view that educational equivalency, not accreditation hierarchy, better predicts readiness for competent psychological practice.

2.2. Conceptual Framework

This study examines the educational and licensing equivalency of doctoral- and master's-level therapists in California through the lens of barriers to Veteran mental health care. To situate the research within a broader theoretical context, this chapter employs a conceptual framework integrating three interrelated theories: Competency-Based Education (CBE), Human Capital Theory (HCT), and Access-to-Care Models (ACM). Together, these frameworks explain how educational design, professional credentialing, and systemic structures intersect to shape the accessibility and quality of mental health care for Veterans.

Competency-Based Education (CBE) Framework

The Competency-Based Education model asserts that professional qualification should be determined by demonstrated skills, performance, and mastery of com-

petencies rather than by seat time, degree title, or institutional prestige (Frank et al., 2010). In the context of mental health training, CBE emphasizes practical competence in ethical practice, assessment, intervention, and cultural responsiveness—criteria defined by both the APA Competency Benchmarks for Professional Psychology (APA, 2011) and the California Board of Psychology (BOP).

Within the CBE framework, mastery is evidenced by performance outcomes (e.g., supervision evaluations, licensure exams, and applied clinical hours), not the formal level of the degree. This perspective aligns with California’s “substantial equivalency” policy, which allows graduates of regionally accredited, non-APA-accredited programs to obtain licensure if they demonstrate the same competencies as APA graduates.

By viewing the educational pathways of doctoral and master’s-level therapists through the lens of CBE, this study explores whether differences in degree designation reflect actual differences in practitioner competence—or whether such distinctions function as symbolic credentials that do not correlate with superior patient outcomes.

In Veteran mental health care, where clinical proficiency and trauma-informed competence are paramount, a CBE perspective suggests that an LMFT or LPCC with equivalent supervised experience may be equally capable of delivering effective treatment as a licensed psychologist. This framework thus supports evaluating therapists based on clinical outcomes and skill performance rather than on hierarchical academic credentials.

Human Capital Theory (HCT)

Originally developed by Becker (1964), Human Capital Theory posits that education and training constitute investments in individuals that yield measurable economic and social returns. Applied to psychology and mental health professions, HCT implies that higher levels of education—such as doctoral training—should theoretically produce greater productivity, competence, and economic value.

However, contemporary research challenges this assumption in the context of psychotherapy. Campbell, Worrell, and Dailey (2018) and Ozelie et al. (2020) found that doctoral education does not necessarily enhance clinical effectiveness compared to master’s-level training, suggesting that the marginal returns of doctoral investment may be overstated in applied mental health work.

By applying HCT to this study, the comparison between master’s and doctoral programs becomes a question of efficiency and equity: Does the additional cost, time, and debt associated with doctoral education yield proportional benefits in the quality of care for Veterans? If not, the persistence of degree-based barriers could represent an inefficient allocation of human capital in the mental health system.

Furthermore, the theory helps articulate the economic dimensions of care access: limiting practice authority or hiring eligibility to doctoral-level clinicians artificially constrains the supply of qualified providers, inflating costs, and restrict-

ing Veterans' access to timely services. Reframing credentialing through the lens of HCT thus supports the rationale for greater educational and professional parity among therapists who demonstrate equivalent competencies.

Labor Market Signaling Theory

According to Spence's Labor Market Signaling Theory, educational credentials often function less as direct measures of competence and more as symbolic indicators that employers use to infer productivity or professional quality (Karasek III & Bryant, 2012). Within the mental health profession, doctoral degrees may signal greater expertise to institutions, even when master's-level clinicians possess equivalent clinical skills and supervised experience. This signaling dynamic perpetuates degree hierarchies that have limited empirical grounding.

In the context of Veteran mental health care, such signaling mechanisms contribute to inefficiencies in workforce utilization, as agencies may overvalue the "signal" of a doctoral credential while underutilizing equally competent master's-level clinicians. Recognizing and reforming these credential signals could therefore expand access to care without compromising quality.

Professional Socialization Theory

Hall's Professional Socialization Theory further explains how cultural norms and prestige hierarchies within professions sustain credential-based distinctions (Thomas, 2020). Over time, psychology has elevated the doctoral degree as the "gold standard" of identity and status, even when empirical evidence shows minimal difference in applied clinical skill.

This framework contextualizes the educational inequity observed in this study as not merely structural, but sociocultural—reinforced by traditions of prestige, status signaling, and historical precedent. Thus, the persistence of doctoral privilege within Veteran care systems reflects a professional identity pattern, not a competency-based necessity.

Access-to-Care Models (ACM)

The Access-to-Care Model, first articulated by Andersen (1968) and later adapted for behavioral health, identifies three primary determinants of healthcare access: predisposing factors, enabling factors, and need factors. Within Veteran mental health systems, enabling factors such as provider availability, licensure policies, and reimbursement restrictions often determine whether Veterans can receive timely and culturally competent treatment (Vogt et al., 2020).

In this context, restrictive licensure rules—particularly those privileging doctoral degrees over master's-level credentials—constitute structural barriers to care. For Veterans, this barrier manifests as long wait times, limited therapy options, and a lack of continuity of care across VA and community systems.

By situating educational equivalency within the Access-to-Care framework, this study interprets degree-based licensing hierarchies as systemic gatekeeping mechanisms that inadvertently limit service accessibility. Expanding licensure and employment opportunities for qualified master's-level therapists could thus reduce these systemic barriers, improving Veterans' ability to access evidence-based treat-

ment without delay.

Integration of Frameworks

Collectively, these frameworks support the premise that degree-based hierarchies within mental health licensing may not be educationally justified and may, in fact, undermine the efficiency and equity of care delivery, particularly for Veterans. This integrated conceptual lens, therefore, guides the analysis of how California's licensing structures can be optimized to prioritize competence and accessibility over academic pedigree.

The conceptual framework guiding this research positions educational equivalency as both an academic and policy question. By applying Competency-Based Education, Human Capital Theory, and Access-to-Care Models, the study evaluates how current licensing distinctions influence the structure and accessibility of Veteran mental health care in California.

The underlying premise is that competence, not credentialism, should determine professional readiness. If master's-level therapists possess the same educational preparation and supervised experience as doctoral-level clinicians, then systemic barriers that restrict their participation in Veteran-serving roles may be both unjustified and detrimental to public health goals.

This framework provides the foundation for the subsequent methodological design, which compares program curricula, licensing requirements, and accreditation structures across APA-accredited, non-APA-accredited, and online therapy programs in California.

3. Methodology

This study employs a within-group, comparative content analysis design examining APA-accredited doctoral programs in California that award a master's degree as a part of doctoral completion. The design isolates the dissertation requirement as the primary variable distinguishing doctoral-level education from master's-level clinical preparation.

This controlled approach eliminates confounding factors associated with comparing institutions of differing accreditation, faculty, or curricula. By analyzing only APA-accredited universities that confer both degrees, the study ensures that curricular content, supervision quality, and institutional rigor are held constant, allowing for a precise examination of whether the dissertation phase contributes to additional competencies relevant to clinical practice or Veteran care.

A Veteran is operationally defined as a former member of the Armed Forces possessing a discharge or DD-214. A Service Member is defined as an individual currently serving in the Armed Forces in an Active, Reserve, or National Guard component. Veteran and Military Service Members are identified as independent cultures and independent of one another (Cameron, 2023).

The purpose of this study is to compare the educational content, practicum requirements, and professional competencies of master's-level and doctoral-level therapy programs in clinical psychology and marriage and family therapy. The

goal is to determine whether meaningful educational or clinical differences exist that justify differential professional status, scope of practice, or compensation.

If findings reveal equivalence in core training and applied skills, the study could contribute to policy discussions about broadening access to mental health services—particularly by supporting professional parity between qualified master’s and doctoral clinicians. This design provides controlled intra-institutional comparisons, ensuring that differences in accreditation body or institutional mission do not confound outcomes.

Data and Analysis

Data for this study were derived from a comparative content analysis of 32 APA-accredited doctoral programs in clinical psychology in California and the corresponding master’s-level programs offered by the same institutions. Focusing on universities with dual-level offerings eliminated institutional variability, ensuring that any observed differences in educational structure could be attributed to degree level rather than program design. Of the 32 doctoral programs analyzed, 28 (87.5%) conferred a master’s degree in psychology before dissertation completion, following completion of the core clinical curriculum, and practicum requirements.

Program information was gathered from publicly available university catalogs, accreditation documents, and program handbooks covering the 2023-2025 academic years. Each program’s curriculum was coded for variables including total credit hours, supervised clinical hours, inclusion of research or dissertation requirements, and scope of practice language. Curricular equivalency was measured by the percentage of overlapping courses across degree levels, using categories derived from the APA Competency Benchmarks Framework (APA, 2011) and the California Board of Psychology’s Title 16 §1387 regulations. Additional data were extracted from the Board of Behavioral Sciences (BBS) licensure requirements for Marriage and Family Therapists (MFTs) and Licensed Professional Clinical Counselors (LPCCs), both of which mandate 3000 supervised clinical hours—a total identical to the Board of Psychology (BOP) requirement for doctoral candidates.

Data analysis proceeded in two phases. First, quantitative comparison of curricular structures and supervised hour requirements established measurable equivalency across programs. Mean total credit hours for master’s-level programs ranged from 60 to 72, compared to 90 to 120 for doctoral programs; however, 80% - 85% of coursework in core domains (psychopathology, ethics, multicultural competence, assessment, and treatment) was identical. Supervised experience requirements showed 100% overlap, as both degree pathways required 3000 hours for licensure eligibility.

Second, a directed qualitative content analysis (Hsieh & Shannon, 2005) was conducted on program descriptions and accreditation statements to distinguish between clinical and research competencies. The analysis revealed that the doc-

toral dissertation—the only unique requirement at the doctoral level—focused on research methodology and scholarly inquiry rather than direct clinical skill development. No new therapeutic, diagnostic, or assessment competencies were introduced during the dissertation phase.

Finally, data were cross-referenced with California licensure statutes (BOP §2914; BBS §4980) and VA provider classification standards (GS-0180) to evaluate how educational distinctions translate into professional eligibility. Despite equivalent competencies, VA classification policies restrict full clinical psychologist roles to doctoral graduates, excluding master's-level clinicians from many Veteran-serving positions. This structural restriction, unsupported by training data, was interpreted as a credential-based barrier to care access under the Access-to-Care Model (Andersen, 1968).

In sum, data from all institutional, regulatory, and accreditation sources demonstrated functional educational equivalency between master's-level and doctoral-level training in clinical practice, supervision, and ethics. The only distinguishing academic component, the dissertation, served as a research credential rather than a competency-based clinical requirement. These findings substantiate the study's central conclusion: that degree-based differentiation in licensure and employment policy reflects institutional tradition rather than evidence-based differences in clinical competence.

This study involves the analysis of publicly available institutional and regulatory data. No human subjects are involved; therefore, it qualifies as exempt under 45 CFR §46.104(d)(4). However, all institutional data are cited and contextualized accurately to ensure fairness and transparency in interpretation.

The researcher's dual academic and professional background uniquely informs this study. Having completed both a master's degree in psychology leading to Marriage and Family Therapy (MFT) licensure and a doctoral degree (Psy.D.) in clinical psychology, the researcher has directly experienced the educational overlap and curricular equivalencies that form the foundation of this inquiry.

This dual perspective provides valuable insight into how clinical competence is developed and assessed across degree levels, but also introduces the potential for bias through personal experience. Reflexivity was therefore maintained throughout all phases of data collection and analysis. Interpretations were grounded in documented program materials, accreditation standards, and licensing regulations to ensure that findings reflect objective equivalency rather than personal perspective.

The reflexive stance strengthens methodological transparency, aligning with APA Ethical Standard 1.08, which emphasizes researcher accountability and integrity in scholarly analysis.

4. Results

This chapter presents the results of a comparative analysis between APA-accredited doctoral programs and master's-level therapy programs at the same institutions in California (Table 1). The purpose of this analysis was to determine

whether doctoral training in clinical psychology provides additional academic or clinical preparation relevant to the treatment of Veterans beyond what is required for master's-level licensure (MFT/LPCC).

Table 1. Quantitative equivalency findings.

Variables	Table Column Head		
	APA Doctoral Programs	Master's-Level Programs (Same Institutions)	Equivalency Finding
Core Coursework Hours	72 - 90 credits*	60 - 72 credits	≥80% overlap
Supervised Clinical Hours	3000	3000	100% identical
Research/Dissertation	Required for doctorate; not for master's	Optional or Not required	No demonstrated link to clinical competency
Scope of Practice	Clinical diagnosis and treatment	Clinical diagnosis and treatment	Equivalent within competence
Assessment Competence	Acquired via coursework + supervision	Acquired via coursework + supervision	Equivalent during training phase

*Note: Disparity in credits correlates with dissertation courses.

4.1. Program Alignment and Master's Conferral Within Doctoral Tracks

Of the 32 APA-accredited doctoral programs in California, 28 (87.5%) confer a master's degree in psychology upon completion of the core coursework and practicum requirements—typically before the dissertation and internship phases.

These intermediate degrees (often M.A. or M.S. in Psychology) represent completion of all clinical and academic training necessary for master's-level licensure in California. Students awarded these master's degrees have completed coursework in psychopathology, ethics, assessment, research methods, multicultural counseling, and evidence-based treatment, core requirements identified by both the California Board of Behavioral Sciences (BBS) and the Board of Psychology (BOP) for licensure eligibility.

This structure demonstrates that, within APA-accredited programs, the clinical and didactic components qualifying graduates for licensure are completed before the dissertation. The dissertation, therefore, functions primarily as a research credential, not a determinant of clinical competency. Ironically, regardless of the credential as a PhD, PsyD, or even an MFT is eligible to conduct and publish research, making the "research credential" void.

4.2. Licensing Requirements: BOP and BBS Equivalency

Both the BOP (psychologists) and the BBS (LMFTs, LPCCs) require a qualifying

graduate degree and 3000 supervised clinical hours for licensure. The structure and supervised hour requirements are identical in total duration and functional purpose. The boards differ primarily in their required degree level and exam type, not in the competencies being assessed.

4.3. Scope of Practice and Professional Competence

Analysis of the [California Business and Professions Code \(2024\)](#) (BPC §2914 for BOP, §4980 for BBS) and the APA Ethics Code revealed that both regulatory bodies define professional scope in terms of competence, not degree level. Both licensed psychologists and master's-level therapists are authorized to:

Diagnose and treat mental and emotional disorders; conduct therapy with individuals, couples, families, children, and groups; and use assessments or measures “within the boundaries of their competence.”

The [APA \(2017\)](#) and [BBS \(2024\)](#) both state that professional competence, not degree title, governs the ethical use of assessment instruments. Doctoral trainees and master's interns both administer psychological assessments under supervision with equivalent coursework in psychometrics, assessment ethics, and data interpretation.

4.4. Findings

Finding 1: The Dissertation is Not a Clinical Competency Requirement

Across 28 of 32 APA programs reviewed, the dissertation is a research-focused capstone project completed after all core clinical coursework and practicum hours. Because students earn a master's degree before beginning dissertation research, they possess full eligibility for BBS licensure at that point.

This finding supports the interpretation that doctoral research requirements do not constitute a fundamental component of the academic preparation required for clinical practice, including the treatment of Veterans. Rather, the dissertation differentiates research proficiency, not clinical competence.

Finding 2: Equal Regulatory Emphasis on Competence

Both the BOP and BBS articulate that professional competence—not degree level—determines authorization to administer specific assessments or treatments. During training, doctoral and master's students receive equivalent instruction in clinical interviewing, diagnosis, ethics, and therapeutic intervention.

Thus, both boards enforce competency-based practice standards, aligning with the Competency-Based Education (CBE) framework rather than an educational hierarchy model.

Finding 3: Structural Redundancy and Human Capital Inefficiency

Applying Human Capital Theory ([Becker, 1964](#)), these findings suggest diminishing educational returns for doctoral-level investment in relation to direct clinical competence. The additional years and tuition required for a Psy.D. or Ph.D. do not yield a corresponding increase in scope of practice, as both degrees ultimately require the same supervised experience and demonstrate comparable skill

competencies.

This redundancy represents a systemic inefficiency in mental health workforce development—particularly significant given the acute shortage of Veteran-serving clinicians in California and nationally.

Finding 4: Degree-Based Credentialing as a Barrier to Veteran Care

The Access-to-Care Model (Andersen, 1968) highlights how system-level barriers restrict health service delivery. Under current VA and federal employment classifications (GS-0180 “Psychologist”), master’s-level clinicians are often excluded from full-time clinical positions despite having equivalent clinical training.

Given that doctoral-level clinicians are in shorter supply, this barrier directly constrains Veterans’ access to timely, qualified care. Expanding recognition of MFTs and LPCCs in VA systems would immediately increase provider availability without compromising treatment quality.

In sum, the analysis reveals no fundamental educational or clinical difference between master’s-level therapists and doctoral-level psychologists in California as it relates to the practice of psychotherapy and assessment within scope of competence.

Key conclusions:

- 1) Clinical equivalency exists in coursework, supervision, and licensure preparation between doctoral and master’s-level psychology degrees, resulting in licensure.
- 2) The dissertation does not constitute a clinical requirement for licensure or treatment readiness.
- 3) Both licensing boards enforce competency-based standards that already support professional parity.
- 4) Current degree-based restrictions in Veteran care systems, including clinical assessment, create artificial workforce barriers, reducing access without improving outcomes.

These findings substantiate the central argument that educational hierarchy, rather than educational substance, underpins the differential treatment of master’s- and doctoral-level therapists—a distinction that, when applied to the Veteran mental health system, perpetuates preventable inequities in access to care.

The findings of this study demonstrate a clear structural and functional equivalence between the educational preparation of master’s-level therapists and doctoral-level psychologists in California. When analyzed through the lens of Competency-Based Education (CBE), the data suggest that both training pathways achieve the same core professional competencies required for licensure and ethical practice. Both the California Board of Psychology (BOP) and the Board of Behavioral Sciences (BBS) emphasize competence, rather than degree title, as the standard for clinical authorization. Given that 87.5% of APA-accredited doctoral programs confer a master’s degree after completion of core coursework and practicum, it is evident that clinical competency is acquired before the dissertation phase. Therefore, the dissertation serves primarily as an academic research re-

quirement, not a determinant of professional skill.

From the perspective of Human Capital Theory (HCT) (Becker, 1964), these results indicate an inefficiency in the allocation of educational resources within the mental health workforce. The additional years, tuition, and opportunity costs associated with doctoral-level education do not yield proportional increases in clinical effectiveness or licensure scope. Both doctoral and master's graduates must complete 3000 supervised clinical hours and pass competency-based examinations, yet only doctoral holders are eligible for psychologist-level positions in many systems, including the Department of Veterans Affairs (VA). This hierarchy produces a systemic underutilization of qualified clinicians and represents a misalignment between educational investment and workforce productivity.

Finally, interpreted through the Access-to-Care Model (Andersen, 1968), degree-based credentialing acts as a structural barrier to service availability for Veterans. Despite equivalency in clinical preparation, VA employment classifications (GS-0180 series) restrict the hiring of master's-level therapists for many clinical positions. This limitation reduces the number of available providers, particularly in rural and underserved regions, contributing to prolonged wait times and unmet mental health needs among Veterans. Broadening eligibility to include state-licensed master's-level clinicians would immediately expand the Veteran-serving workforce without compromising quality of care.

Taken together, the results reveal that educational hierarchy, not competency difference, underpins current licensure and employment distinctions. Recognizing this equivalency could promote a more efficient and equitable system, where demonstrated clinical competence, rather than academic degree, determines professional opportunity and access to mental health care for those who have served.

5. Discussion

The purpose of this study was to compare the educational and licensing standards of doctoral-level and master's-level therapists in California and to evaluate how these differences influence Veteran access to mental health care. Using comparative analysis of APA-accredited doctoral programs and parallel master's-level therapy programs at the same institutions, the study sought to determine whether the additional research components of doctoral education substantively enhance clinical competence.

The findings demonstrate that clinical coursework, supervised hours, and competency benchmarks are equivalent across degrees and that the doctoral dissertation, while academically valuable, does not represent a fundamental element of clinical preparation. Both the California Board of Psychology (BOP) and the Board of Behavioral Sciences (BBS) enforce similar competency-based licensing frameworks, requiring equivalent supervised experience and adherence to professional scope and ethics.

These results suggest that degree-based distinctions are structural artifacts rather than reflections of measurable clinical differences and that they function as

barriers to Veteran care within both state and federal systems.

5.1. Interpretation of Findings

Equivalency in Educational and Clinical Competence

The core finding of this research—that 28 of California’s 32 APA-accredited doctoral programs confer a master’s degree after core clinical coursework and practicum completion, reveals that master’s-level clinical competence is achieved midway through doctoral training. This finding challenges the traditional assumption that doctoral education is necessary for effective therapeutic practice.

Both doctoral and master’s programs require 3000 supervised clinical hours, and both emphasize evidence-based interventions, multicultural competence, and ethical standards. Doctoral students who earn a master’s en route to their degree possess the same qualifications as LMFT or LPCC candidates to provide therapy under supervision, indicating that clinical readiness precedes dissertation completion.

This equivalence underscores the central argument of Competency-Based Education (CBE): clinical competence is demonstrated through applied performance, not degree title. The dissertation phase of doctoral programs, while academically enriching, contributes primarily to research literacy, not to direct therapeutic skill.

5.2. The Dissertation as a Symbolic, Not Functional, Distinction

It can be argued that the dissertation holds some value in providing an experience in conducting research from inception to publication, but it is not a clinical skill. A research project cannot ethically be the sole determining factor in the distinction in capabilities or education between a master’s-level therapist, such as an LMFT, and a Clinical Psychologist.

The finding that the dissertation is completed after licensure-qualifying coursework and practicum indicates that it is a symbolic academic differentiator rather than a functional professional one. Within the CBE framework, this means that doctoral-level education adds prestige and research capability but does not enhance a graduate’s immediate ability to provide clinical care.

This distinction becomes critical when evaluating the Veteran mental health system, where access, not research output, is the central public health priority. If the dissertation does not meaningfully increase therapeutic competence, then maintaining degree-based hiring hierarchies in the VA system is educationally unjustified and ethically questionable in light of provider shortages and Veteran suicide statistics.

5.3. Human Capital Efficiency and Workforce Utilization

From the perspective of Human Capital Theory (Becker, 1964), requiring doctoral-level credentials for clinical practice in Veteran care represents an inefficient use of educational resources. Doctoral education typically extends three to five

years beyond the master's level, increasing student debt and delaying workforce entry without proportional increases in clinical effectiveness.

This inefficiency has measurable consequences. The VA's 2023 Workforce Report identified a persistent shortage of clinical psychologists and high vacancy rates in behavioral health positions. Meanwhile, thousands of licensed LMFTs and LPCCs in California remain underutilized in federal systems despite holding equivalent clinical training.

By restricting VA hiring to doctoral-level clinicians, the system inadvertently inflates workforce costs, narrows supply, and prolongs access delays—all while Veterans in rural and underserved regions face prolonged wait times for care. Thus, under HCT, degree-based credentialing constitutes a form of human capital misallocation.

5.4. Access-to-Care Barriers for Veterans

The Access-to-Care Model (Andersen, 1968) identifies policy, economic, and organizational structures as “enabling factors” that determine service accessibility. Within the VA system, degree-based credentialing serves as such a structure. Although both doctoral and master's-level therapists meet California's licensure standards, only psychologists classified under the federal GS-0180 series are eligible for full clinical roles in VA hospitals.

This exclusion effectively removes a large segment of the qualified workforce from direct service provision. LMFTs and LPCCs are limited to community care networks or contract-based roles, which are often lower-paid, less stable, and geographically restricted. As a result, Veterans encounter reduced provider options and longer wait times, especially in rural counties where the psychologist-to-Veteran ratio is critically low.

From an ACM perspective, this constitutes a systemic access inequity. The barrier is not clinical competence; it is credentialism.

5.5. Implications for Policy and Practice

1) State-Level Implications (California)

California's licensing system already demonstrates competency-based equivalency across degrees. Because the BOP and BBS both require 3000 hours of supervised experience and comparable coursework, the state could take a national leadership role by advocating for licensure parity across federal systems.

Policy Recommendation:

- The California Department of Veterans Affairs (CalVet) and BOP/BBS could jointly petition the VA to expand clinical eligibility criteria to include BBS-licensed clinicians (LMFTs, LPCCs) for GS-0180-equivalent roles.
- Licensure portability reforms could formalize California's substantial equivalency standards at the federal level, allowing non-APA graduates to practice within the VA under state licensure verification.

2) Federal-Level Implications (Department of Veterans Affairs)

At the national level, the findings support revising the VA's hiring standards to recognize state-licensed master's-level clinicians as equivalent in clinical competency to psychologists for psychotherapy delivery.

Policy Recommendation:

- Reclassify LMFTs and LPCCs as eligible mental health providers under the GS-0180 or new GS-0184 classification for mental health counseling.
- Establish a VA Credentialing Equivalency Review Board to evaluate degree parity and competency equivalency among state-licensed clinicians.
- Allow reimbursement parity under TRICARE and VA Community Care programs for therapy services delivered by BBS-licensed providers.

These changes would immediately expand the VA's workforce capacity, especially in regions facing chronic shortages of doctoral-level clinicians.

3) Educational Policy Implications

At the institutional level, the results call for a reevaluation of the purpose of the dissertation within clinical psychology programs. While research training is valuable for scientific literacy, it should not be conflated with clinical qualification.

Policy Recommendation:

- APA-accredited programs should differentiate between clinical and research competencies and clarify that licensure readiness occurs after completion of the clinical core.
- Institutions may offer a clinical doctorate without a dissertation requirement (e.g., Psy.D. in Applied Psychology) for students intending to pursue practice rather than academia.
- Universities could also facilitate dual-track models that award both licensure-qualifying master's degrees and optional research doctorates, reducing educational redundancy.

Projected Policy Impact

Based on current workforce data, California employs over 12,000 active LMFTs and LPCCs (BBS, 2024), compared with approximately 3,500 licensed clinical psychologists (BOP, 2024). If even 20% of the master's-level clinicians were recognized for direct VA service eligibility, the mental health workforce available to Veterans could increase by approximately 2,400 providers statewide, a 68% expansion in therapeutic capacity.

Assuming standard caseloads of 25 clients per month, this parity-based inclusion could create over 720,000 additional therapy sessions annually, drastically reducing access delays and aligning with the VA's National Strategy for Preventing Veteran Suicide (U.S. Department of Veterans Affairs, 2023b).

These estimates demonstrate the tangible impact of transitioning from degree-based to competence-based recognition frameworks in federal and state Veteran care systems.

Future studies should:

- 1) Analyze Veteran outcome data comparing treatment effectiveness between LMFTs, LPCCs, and psychologists.

2) Examine economic impact analyses of expanding master's-level inclusion within VA systems (e.g., cost per session, wait time reduction).

3) Investigate educational cost-benefit ratios for doctoral versus master's-level clinicians entering Veteran care pathways.

4) Explore Veterans' preferences for provider type, as therapeutic alliance may depend more on relational competence than degree title.

Implications for Training and Accreditation

Findings from this study suggest that graduate training institutions and accrediting bodies should reexamine the structural relationship between master's and doctoral education. APA-accredited programs might consider implementing dual-track clinical pathways, allowing students to complete a clinically focused doctorate (Psy.D.-Practice) without the dissertation requirement, while maintaining the option for a research-oriented Ph.D.

Similarly, master's programs accredited by COAMFTE or CACREP could partner with APA-accredited institutions to establish articulated transfer pathways, ensuring that master's graduates receive full recognition of prior competencies if they pursue doctoral-level training.

Such reforms would reduce educational redundancy, expand the supply of clinically competent practitioners, and accelerate the integration of master's-level clinicians into Veteran-serving systems.

5.6. Counterarguments

“Doctoral Training Provides Superior skills in supervision and Assessment.”

If the research conclusions didn't address this fallacy, then the university's own programming should. Not all universities are the same. This is not about the marketing capabilities of a university, but the competencies required to engage in mental health treatment. Universities are quantifying and qualifying their doctoral programs over a master's degree via a dissertation, a research paper that in theory, can be satisfied by conducting a meta-analysis on other people's research.

“If they are equal, then why are there separate licensing boards?”

The answer to this question might be worthy of its own research. Yet, the logical explanation based on this data is that it is more about gatekeeping and potentially an elitist mentality. The research concludes that there is no practical difference in education or competency between the two degree levels. It can be argued that if an individual is a licensed mental health provider based on a master's-level degree and goes on to complete a doctorate eligible for licensure, they should have their credential accepted without any additional examination or supervision requirements.

5.7. Limitations

While the study reveals strong structural equivalency between degree levels, it did not directly measure client outcomes among Veterans served by each clinician type. Future research should use quantitative outcome data (e.g., symptom reduc-

tion, satisfaction, retention) to confirm that educational equivalency translates to treatment effectiveness.

Additionally, the study's focus on California limits generalizability to states with different licensure standards. However, California's size, diversity, and policy leadership make it an ideal prototype for national reform.

6. Conclusion

This study found no evidence that doctoral-level education in psychology confers superior clinical competency compared to master's-level training in the context of psychotherapy or assessment for Veterans. Both pathways provide equivalent preparation for the treatment of mental, emotional, and behavioral disorders, governed by identical supervision and ethical standards.

In short, educational hierarchy is not equivalent to clinical superiority. The persistence of degree-based restrictions constitutes a systemic barrier to Veteran mental health access. The evidence supports a policy shift toward competency-based equivalency and inclusive licensure recognition, a reform that would not only enhance efficiency but could immediately expand the mental health workforce, reduce wait times, and improve the quality and continuity of care for Veterans.

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Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

References

- American Psychological Association (APA) (2011). *Competency Benchmarks for Professional Psychology*. <https://www.apa.org/ed/graduate/competency>
- American Psychological Association (APA) (2017). *Ethical Principles of Psychologists and Code of Conduct*. <https://www.apa.org/ethics/code>
- Andersen, R. M. (1968). *A Behavioral Model of Families' Use of Health Services*. Center for Health Administration Studies, University of Chicago.
- Becker, G. S. (1964). *Human Capital: A Theoretical and Empirical Analysis, with Special Reference to Education*. University of Chicago Press.
- Board of Behavioral Sciences (BBS). (2024). *Laws and Regulations Related to the Practice of Marriage and Family Therapy, Educational Psychology, and Clinical Counseling*. California Department of Consumer Affairs. <https://bbs.ca.gov/lawsregs/index.html>
- Board of Psychology (BOP). (2024). *California Code of Regulations, Title 16, Division 13.1, §1387-Supervised Professional Experience*. California Department of Consumer Affairs. https://psychology.ca.gov/laws_regs/index.shtml

- California Business and Professions Code (2024). §§2914-2915 (*Psychology*), §§4980.40-4980.80 (*Marriage and Family Therapy*), and §§4999.30-4999.120 (*Professional Clinical Counseling*). California Statutes Relating to Behavioral Sciences.
- CalVet (California Department of Veterans Affairs) (2024). *Veterans Mental Health and Suicide Prevention Strategy*.
<https://www.calvet.ca.gov/VetServices/Pages/Mental-Health.aspx>
- Cameron, K. (2023). Veteran Evolution: Re-Classifying the Military and Veterans as Independent Cultures. *Advances in Applied Sociology*, 13, 47-95.
<https://doi.org/10.4236/aasoci.2023.131005>
- Campbell, L. F., Worrell, F. C., Dailey, A. T., & Brown, R. T. (2018). Master's Level Practice: Introduction, History, and Current Status. *Professional Psychology: Research and Practice*, 49, 299-305. <https://doi.org/10.1037/pro0000202>
- Chabot, M. C., Frye, S. K., Lynn, N., Meyer, K., Lockhart-Keene, L., Navarro-Walker, L. et al. (2024). Occupational Therapy Practitioners' Expectations of Entry-Level Doctorate versus Master's Graduates. *Journal of Occupational Therapy Education*, 8, 45-59.
<https://doi.org/10.26681/jote.2024.080312>
- Frank, J. R., Snell, L. S., Cate, O. T., Holmboe, E. S., Carraccio, C., Swing, S. R. et al. (2010). Competency-Based Medical Education: Theory to Practice. *Medical Teacher*, 32, 638-645. <https://doi.org/10.3109/0142159x.2010.501190>
- Godfrey, C. A. (2020). *Factors Affecting Master's Counseling Students Pursuing Doctoral Degrees*. Doctoral Dissertation, Walden University.
<https://scholarworks.waldenu.edu/dissertations/>
- Hsieh, H., & Shannon, S. E. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*, 15, 1277-1288. <https://doi.org/10.1177/1049732305276687>
- Karasek III, R., & Bryant, P. (2012). Signaling Theory: Past, Present, and Future. *Academy of Strategic Management Journal*, 11, 91.
- Lemez, S., & Jimenez, D. (2022). Occupational Therapy Education and Entry-Level Practice: A Systematic Review. *Education Sciences*, 12, Article 431.
<https://doi.org/10.3390/educsci12070431>
- Muir, S. (2016). *Supervisor Perceptions of Entry-Level Doctorate and Master's of Occupational Therapy Degrees*. Doctoral Dissertation, Walden University.
<https://scholarworks.waldenu.edu/dissertations/3427>
- Ozelie, R., Burks, K. A., Lee, S., Riggilo, K., & Sivak, M. (2020). Masters to Doctorate: Impact of the Transition on One Occupational Therapy Program. *Journal of Occupational Therapy Education*, 4, 1-12. <https://doi.org/10.26681/jote.2020.040309>
- Thew, M. M., & Harkness, D. (2018). Predictors of Practice Placement and Academic Outcomes in Master's-Level Pre-Registration Occupational Therapy Students. *British Journal of Occupational Therapy*, 81, 234-242. <https://doi.org/10.1177/0308022617738467>
- Thomas, S. (2020). Socialization and Professionalism. In *Research on Professional Responsibility and Ethics in Accounting* (pp. 121-139). Emerald Publishing Limited.
- U.S. Department of Veterans Affairs (2023a). *Veterans Health Administration Workforce and Mental Health Services Report*. Office of Mental Health and Suicide Prevention.
<https://www.va.gov/health/annual-reports/program-office.asp>
- U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention (2023b). *National Strategy for Preventing Veteran Suicide, 2018-2028*.
https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf
- Vogt, D., Vaughn, R., & Gorman, J. A. (2020). Barriers to Mental Health Care Use among

Returning Veterans: A Systems-Level Perspective. *Psychological Services*, 17, 15-26.
WASC Senior College and University Commission (WSCUC) (2024). *Accreditation Handbook*. <https://www.wscuc.org/handbook>