

## COMMENTARY

# Reconsidering the Integration of Science and Practice in Training in Clinical Psychology

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Clinical psychology as a field has fallen short of its potential to ameliorate the tremendous, ever-growing burden associated with mental disorders. This article provides an overview of how current approaches to training in clinical psychology contribute to this shortfall. First, an overview of the development of training in clinical psychology and the scientist–practitioner model in the United States and Canada is provided, followed by a discussion of the limitations of this model, which remains the predominant approach to doctoral training in clinical psychology in Canada. An alternative approach to clinical training is proposed in which clinical psychologists take the lead in developing evidence-based curricula for applied training that is implemented at the master’s level. Under this approach, doctoral training would be reserved for trainees interested in research and other relevant aspects of clinical science. This approach to training could produce a large number of evidence-based clinicians quickly and efficiently and would potentially create more jobs for those with PhDs in clinical psychology, among other important benefits.

### *Public Significance Statement*

Doctoral training, which is quite lengthy, is generally required to work as a clinical psychologist in Canada. The current article raises criticisms of this approach to training and proposes an alternative model that is designed to be a more efficient means of producing clinicians with training in empirically supported psychological treatments.

*Keywords:* clinical training, scientist–practitioner, clinical science, scholar–practitioner

Psychology has been described as a “hub discipline” (Cacioppo, 2007) in recognition of the diversity of methods used and research questions pursued by the field (Boyack et al., 2005). In addition to more traditional ways of measuring behaviour (e.g., questionnaire measures; behavioural tasks), contemporary psychological scientists use imaging, psychophysiology, computational modelling, and other complex methods to better understand human behaviour. There is additional heterogeneity within the subdiscipline of clinical psychology, which is concerned with not only a broad array of research questions and complex methodologies but also applied work in the domains of clinical assessment and intervention. Indeed, doctoral-level clinical psychologists might identify primarily as basic psychopathologists, who study the causes of disorder; intervention scientists, who study treatment; or practitioners, who

work with patients. Graduate training in clinical psychology is therefore necessarily complex, as it is intended to produce experts in applied clinical domains and empirical research.

The breadth of research methods, scientific questions, training goals, and occupational outcomes notwithstanding, the field of clinical psychology is generally concerned with the common goal of reducing the devastating burden posed by mental health problems (Gee et al., 2022), a goal that has arguably never been more daunting. The prevalence of mental health problems in industrialized nations has sharply increased in recent cohorts (Rehm & Shield, 2019); this worrisome trend has likely been exacerbated by recent, pervasive stressors with an ongoing impact, such as the COVID-19 pandemic, multiple armed conflicts across the globe, and the climate crisis, among others. Given the strong associations between stress exposures and mental disorder (Harkness & Hayden, 2020), it is likely that the already dire need for effective mental health care will continue to rapidly outpace available resources.

These alarming issues highlight the imperative to reflect on how effectively the field of clinical psychology is mitigating mental disorder burden; as one of the largest groups of regulated mental health care providers in Canada, psychologists have a particularly compelling obligation to engage in such reflection and respond accordingly. Evaluating the impact of the discipline is a complex task that begets questions concerning how successful clinical scientists have been in terms of improving our understanding of the aetiology (Hayden, 2022) and treatment of psychological disorders

This article was published Online First May 16, 2024.

The author is indebted to Kate Harkness and Keith Dobson for their constructive, thoughtful, and extremely helpful feedback on this article. She also grateful to the clinical programme faculty and students at Queen’s University for the valuable conversations she had with them following a talk she gave on this same topic in the spring of 2023.

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and related conditions (Furukawa & Kessler, 2019). A consideration of our field's impact also begs the question of whether the current approach to PhD training in clinical psychology is the best, or at least, an acceptably efficient approach to preparing future clinical psychologists to reduce the suffering imposed by mental health problems. If nothing else, the longevity and predominance of our current approach to clinical training, the scientist–practitioner model (described in the next section), suggest that it is time to reflect on how well it is serving the field and the pressing mental health needs of Canadians.

In the current article, I briefly describe the origins and evolution of doctoral training in clinical psychology. I highlight the limitations of current approaches to training and suggest an alternative strategy that could enhance both applied and scientific training in the field while also more efficiently addressing the vast, unmet need for empirically supported interventions.

### A Brief History of Science and Practice in Clinical Training

A brief history of the development of our current training model is useful towards understanding its current status.<sup>1</sup> Graduate training in clinical psychology as we know it emerged from the need to provide mental health care and other psychological services to veterans of World War II. Prior to this, psychologists had already established the utility of the profession in the domains of assessment and screening; thus, the provision of treatment was a logical extension. In 1949, the American Psychological Association (APA) and the National Institute of Mental Health collaborated to hold a conference in Boulder, Colorado, to discuss the development of clinical psychology training standards, which had heretofore varied widely across extant programmes. The training philosophy that emerged from the Boulder Conference (i.e., the “Boulder Model”) is instantiated in the *scientist–practitioner training model*, in which doctoral clinical psychological training is a mechanism for producing PhD-holding graduates who are competent in both basic and applied science. In addition to receiving training in assessment, intervention, and research, the model further articulated several key training elements, including the setting for scientist–practitioner training (psychology departments at universities), the degree to be earned by trainees (the PhD), and class sizes (small, to facilitate academic mentorship). In the idealized instantiation of the model, PhD holders continue to engage in both scientific and applied work following receipt of the PhD.

As is true in many domains, Canadian academic psychology has been influenced by American psychology (Adair, 1981); however, Canada has its own history concerning the implementation of training in clinical psychology (see Adair, 1981; Conway, 1984; Davidson, 1970; Dobson, 2016; Nicholson, 2022). In brief, doctoral Canadian clinical psychology training is a relatively recent phenomenon, unfolding somewhat later than the post-World War II, boom in American doctoral clinical psychology (Conway, 1984). In the mid-1900s, most Canadian postgraduate training in psychology was applied, culminating in a master's degree (Conway, 1984). Although detailed information is limited, the applied training provided by these programmes appears neither rigorous nor evidence-based. At that time, the notion of clinical psychology training was viewed sceptically by other academic psychologists, who were generally struggling for recognition as a legitimate scientific discipline within

academia. Thus, towards the goal of garnering academic respectability, Canadian psychology departments elected to emphasize basic research over applied domains (Conway, 1984).

Several conferences held in the 1960s influenced the next stage of the development of Canadian training in clinical psychology (Conway, 1984). The Opinicon Conference (1960; Bernhardt, 1961) was focused on developing research and research training in psychology, not applied training; however, a few years later, the Canadian Psychological Associations (CPA's) 1965 Couchiching Conference (Webster, 1967) helped establish scientist–practitioner training as the standard for graduate training in clinical psychology in Canada. Despite conference attendees' call for the CPA to establish an accreditation process for doctoral training in applied psychology, the CPA demurred, arguing that provincial psychological associations were better equipped to establish more local training standards. Indeed, some provincial psychological associations went on to accredit training programmes and many Canadian programmes sought accreditation by the APA instead.

Meanwhile, between 1965 and 1980, there was a tremendous expansion of academic psychology across Canada, including an increase in departments with clinical psychology programmes. This expansion was accompanied by greater regional diversity of clinical training (Conway, 1984). The influx of American-trained psychologists during this time (Conway, 1984) further maintained the United States influence on graduate education in psychology in Canada. In 1983, the Council of Clinical Psychology Programme Directors unanimously supported the development of accreditation standards consistent with the training described in the scientist–practitioner model (Conway, 1984) and CPA began accrediting programmes in 1984 (Dobson, 2016). Although there have been attempts to develop a distinct Canadian clinical training model (e.g., Davidson, 1970), none garnered momentum and to date, virtually all Canadian doctoral training programmes in clinical psychology adhere to scientist–practitioner training.<sup>2</sup>

### Inefficiency: The Problem With Dual Training

Thus, for decades now, the integrated training that serves as the foundation of scientist–practitioner training has been the predominant model of doctoral training in clinical psychology in Canada (Davidson, 1970; Dobson, 2016) and in the United States. However, the very real, practical inefficiencies associated with the ambitious goal of training students to be both expert clinicians and researchers were noted early on, contemporaneous to the emergence of the scientist–practitioner model itself (APA, 1950). These have been articulated in detail elsewhere (e.g., Frank, 1984; Meehl, 1971, 1987); therefore, the overview that follows is brief.

### Small Class Sizes

In 1971, Meehl wrote, “it is admitted by all who are acquainted with the statistical facts that current doctoral programmes in clinical psychology must inevitably fail to meet society's mental health

<sup>1</sup> The development of the scientist–practitioner model, debates regarding its utility, and the emergence of other models have been described in great detail elsewhere. I refer the interested reader to Barlow (1981), Frank (1984), McFall (2006), and Routh (2015) for more detail.

<sup>2</sup> The interested reader may wish to read Nicholson (2022), for a detailed review of Canadian clinical psychology training.

needs because they are not turning out an adequate supply of professional personnel” (p. 38). Both then and now, by intent and due to constraints on the number of students who can be adequately trained within PhD programmes, clinical psychology programmes in North America recruit small incoming classes (e.g., five to 10 students per year), thus limiting the ability of the field to reduce the burden of mental disorder, at least in terms of producing ample frontline service providers.

However, even if universities were to increase clinical psychology PhD class sizes significantly, increasing the number of highly paid frontline mental health care providers may not increase access to services for those with limited financial resources. For example, in comparing different Ontario health networks, Kurdyak et al. (2014) found that, relative to psychiatrists in areas with a lower supply, psychiatrists in higher supply areas saw fewer patients; these patients tended to be wealthier and were seen more frequently and for longer visits, which Kurdyak and colleagues concluded was consistent with psychiatrists electing to provide longer term psychotherapy to a small number of patients who are reliable and relatively straightforward to treat. There are significant and important differences in the practices of psychiatry and clinical psychology, especially with regard to funding for service provision; these differences complicate comparisons of the two professions. However, these findings suggest that, even if Canadian universities could afford to radically expand the size of PhD programmes in clinical psychology, doing so might not increase access to care for those who arguably need it the most.

### Duration of Study

Scientist–practitioner training requires additional time compared to the already lengthy study normally required for a PhD. As noted elsewhere (Gee et al., 2022), in formulating the scientist–practitioner model, it was decided that the goals of doctoral training in clinical psychology were to impart both breadth and depth of knowledge via coursework, a yearlong residency, and an empirical dissertation, to be completed within the same time frame as other subdisciplines of the field (e.g., PhD training in social psychology). Although proponents of the scientist–practitioner model initially assumed that graduate training in clinical psychology would proceed apace to that of other psychology subdisciplines, it quickly became apparent that the demands of dual training required more time spent in graduate school than intended (Gee et al., 2022).

One might ask whether this lengthy, research-focused training clearly produces better clinicians. Although direct studies comparing PhD trainees to others are sparse, the relevant scientific literature does not support the contention that doctoral training is needed to be an effective clinician (Mason et al., 2016; Meehl, 1971; Montgomery et al., 2010; see Wampold & Owen, 2021, for a broader overview). For example, Mason and colleagues found that student trainees generally performed, as well as fully trained clinicians, at administering cognitive behaviour therapy for anxiety; moreover, student therapists used fewer sessions to achieve comparable outcomes. Along similar lines, Montgomery et al. (2010) reported that paraprofessionals, who have been found to produce improvements comparable to clinicians with professional training, were effective providers of cognitive behavioural therapies. This research supports the notion that clinical training can be reduced in length without comprising the efficacy of clinical

interventions; further, this work indicates that models of doctoral training in psychology that emphasize applied training (e.g., scholar–practitioner doctoral training, which results in the PsyD) are not an efficient solution to the concerns I raise in this article, given that these programmes also take many years to complete. However, additional research on whether more extended training is valuable towards training clinicians to treat complex clinical problems may be useful.

It is certainly possible that scientist–practitioner training produces clinicians who are superior to mental health care providers with less training. However, if so, one might reasonably wonder whether any incremental benefit of additional training was attributable to the scientific training our students receive, as opposed to it simply being a by-product of how competitive admission is to clinical programmes and how conscientious and organized one must generally be to complete a PhD. Further, most training programmes take pains to recruit students who are likely to be capable clinicians and scientists; this makes sense, given the current training model. However, it seems possible that aptitude for clinical work and research may not overlap significantly, suggesting that we may be excluding individuals with the potential to be excellent clinicians *or* researchers, if not both. It seems likely that a significant proportion of doctoral clinical students complete the significant research training our programmes entail because it is required for the degree and to practice as clinical psychologists, not because they plan to use these skills postgraduation.

### Feasibility, During and Post-PhD

From the very inception of the scientist–practitioner model, questions about the feasibility of dual training have been raised. However, the evergreen question of the dual training model’s feasibility is more pressing today than ever, given various pressures in the field. In terms of research training, students must acquire increasingly sophisticated and complex research skills to stay apace with the field, rendering it increasingly challenging to balance clinical training and research, especially within the time frame for most PhD training. A corollary of lengthy training is that graduates, who generally subsist on relatively low incomes as graduate students, seek out high-paying positions upon graduation. In Ontario, the recommended hourly rate for clinical psychologists in private practice was set at \$225 in 2015, an out-of-pocket expense that renders such services inaccessible to many. Indeed, among other economic forces, the relative cost of psychologists in Canada has contributed to a stagnation in the number of positions for psychologists in hospitals and other public systems, further reducing access to psychological services (Dobson, 2016). The need for a high income after lengthy doctoral training is understandable; nevertheless, these forces mean that the services of many PhD clinical psychologists will be inaccessible to underserved individuals who need them.

For graduates of clinical programmes who are primarily interested in research, the academic job market has never been more competitive; aspiring professors are expected to have multiple first-authored publications and oftentimes postdoctoral training to be competitive for tenure-track jobs, which are limited in number. Further, heightened pressure to publish and secure grant funding to receive tenure, alongside increasingly stringent registration requirements in some provinces, renders it challenging for early career

academic clinical psychologists to engage in practice. Data are lacking with respect to the challenges that clinical PhD service providers encounter in terms of opportunities to engage in research, but it seems unlikely that many would seek out such opportunities if their employment setting does not expect them to do so.

It is likely that, following graduation, most PhD clinical psychology graduates in Canada are using *either* their scientific or applied training, but not both. Based on the pressures described above, this trend seems likely to continue. Expending increasingly scarce resources on doctoral training that will be irrelevant to the professional activities of the vast majority of our graduates is a costly inefficiency that our field cannot afford.

### Alternative Approaches to Graduate Training in Clinical Psychology

Alternative training models have emerged that, while maintaining the goals of training in science and practice, emphasize either applied training (i.e., the *scholar-practitioner* model, training which often culminates in the PsyD degree) or scientific training, as in the *clinical science* training model. Both alternative models are fairly rare in Canada but have significant representation in clinical psychology training programmes in the United States. Further, the clinical science training model is gradually gaining momentum in Canada, with four of the 34 CPA-accredited doctoral programmes stating that they adhere to this model. Of the other 30 doctoral programmes accredited by the CPA, 24 are scientist-practitioner programmes and a handful identify as scholar-practitioner programmes. The clinical science training model has the significant strength of being outcome-based, in that programmes accredited under its accreditation system must demonstrate that the majority of programme graduates contribute to advancing scientific knowledge post-PhD; presumably, this demonstrates that trainees, or at least the majority of them, are making good use of their scientific training. Nevertheless, all three models are dual training models, entailing significant training in both research and applied clinical psychology. If the inefficiency of dual training is at the heart of the problem, none of the three current training models (i.e., scientist-practitioner, scholar-practitioner, clinical science) resolves this issue, suggesting that more radical solutions might be needed to address the pressing, unmet need for clinicians who are trained in empirically supported behavioural interventions.

In the sections that follow, I provide an overview of an alternative training model in which applied training occurs at the master's-level and doctoral training is focused exclusively on research and other nonapplied activities. This broad overview is intended to facilitate fulsome discussion among relevant stakeholders concerning the implementation of evidence-based master's clinical psychology training. I acknowledge that significant collaboration between the CPA, Canadian universities, and provincial governments and psychological associations would be crucial towards refining and implementing the proposed training model for master's students, described below.

### Changing Master's Training

In the United States and Canada, regulatory bodies have historically required a doctorate to commence professional practice as a psychologist, despite the lack of evidence that doctoral study is

needed to be an effective clinician. However, to meet the increased need for psychological services in the United States, the American Psychological Association Commission on Accreditation (APA-CoA) recently undertook the process of accrediting master's-level psychology programmes (APA-CoA, 2024). The benefits of streamlined training of psychological service providers in Canada have been articulated, both decades ago (e.g., Davidson, 1970) and more recently (e.g., Dobson, 2016). Certainly, master's programmes in psychology are not new; as noted previously, applied master's programmes initially provided the bulk of psychology graduate training in Canada. Many academics involved in doctoral clinical training have viewed such programmes with scepticism, given that they have not been closely regulated and may not have provided high-quality training. To clarify, the argument is not that Canadian psychology master's programmes in their current instantiation provide adequate training; if it were, other provinces would simply need to follow the lead of Alberta and Saskatchewan, which currently register master's-level psychologists, and issues of accreditation would be irrelevant. Rather, the proposal is that the CPA, in discussion with academic clinical psychologists and governmental health organizations, develops rigorous standards for efficient, evidence-based master's-level clinical psychology training as part of a new accreditation process, thereby establishing programmes that train large numbers of master's-level psychologists in evidence-based psychological interventions in only a few years. Rigorous continuing education requirements could also be proposed.

Such master's programmes would ideally be housed in training clinics within existing Canadian university psychology departments, as these environments would presumably foster evidence-informed training and practice. In the proposed model, master's training in clinical psychology would emphasize empirically supported, applied activities (i.e., assessment and intervention) along with some coursework focused on how to evaluate clinical research, towards providing master's-level psychologists with the skills needed to evaluate the evidence base for approaches to clinical assessment and intervention. This latter component of training may require the development of focused courses designed to educate trainees to be knowledgeable consumers of psychotherapy research specifically.

### Changing Doctoral Training

In the proposed approach, doctoral training would focus almost exclusively on research and other nonapplied activities. Doctoral training would have a direct admission stream for those interested in research on clinical phenomena for which clinical training would not be useful. For trainees who intend to study treatment or other applied issues upon receipt of the PhD, completion of master's-level clinical training could be required for admission to PhD programmes, such that trainees complete their clinical training first and then devote their time exclusively to research training as PhD students. Indeed, doctoral graduates of these programmes could ultimately be employed as trainers and potentially supervisors of master's-level clinicians under a tiered system (Dobson, 2016). These doctoral psychologists would be well-poised to use master's-level training programmes not only as a mechanism of training but as a context for research on programme evaluation and treatment efficacy, capitalizing on their scientific training at the doctoral level. Implementing evidence-based, master's-level clinical training in settings that also

serve as vehicles for psychotherapy research could prove highly beneficial towards training clinicians who value empirical evidence.

### Benefits

Eliminating clinical training at the doctoral level would not only allow PhD candidates more time for research, and it would also facilitate other training experiences, such as those involving public policy and advocacy, for example. Additionally, this training model would eliminate the burden currently posed by the yearlong clinical residency, which is not only expensive and stressful for trainees (Knowles et al., 2024) but a major training requirement that very few programmes provide themselves and thus cannot control.<sup>3</sup> Relatedly, this approach to training would eliminate the challenges that many Canadian clinical programmes face in securing evidence-based clinical practica for PhD students. Further, many Canadian clinical PhD students receive Tri-Council funding to support their doctoral research; one might reasonably question the use of funding in this manner, to the extent that many of these students become practitioners following graduation. The proposed change to training would mean that most scholarship funding received by clinical PhD students would go towards supporting candidates who will put their research training to use in their future careers.

Importantly, the significant reduction in time spent in school that would result from a shift to master's training in clinical psychology would have the key benefit of increasing accessibility to clinical psychology training and, therefore, the diversity of the resulting clinical workforce. As noted recently (Goghari, 2022), professional clinical psychologists are less diverse than mental health workers in related fields; some of the lack of diversity likely stems from the socioeconomic adversity that is disproportionately experienced by individuals from racial and ethnic minority groups, which negatively impacts their ability to prepare for and complete a 6-7-year-long programme of study. The current proposal would likely greatly facilitate a more diverse professional force that is better equipped to interface with an increasingly diverse Canadian population.

However, the most significant benefit to the proposed training model is that, in a relatively short amount of time, it would greatly increase access to master's-level clinical psychologists delivering mental health interventions that are evidence-based. Clinical psychology as a discipline has shown a historical commitment to evidence-based practice; for this reason, clinical psychology should embrace the notion of master's-level applied training and take the lead in its implementation, ensuring that training (and even continuing education requirements, ideally) is grounded in the scientific literature. Other disciplines train master's-level clinicians to provide psychotherapy; however, as clinical psychologists, we are uniquely committed to evidence-based interventions for mental health problems. Although it will be challenging to do so, we should extend this commitment by shifting our training approach to respond to the pressing needs of Canadians who suffer from mental disorders.

### Hazards

There are risks associated with the proposed training model. First, this approach to training would likely radically decrease the size of the clinical PhD student applicant pool, which is usually the largest group of applicants to psychology graduate programmes by a wide

measure. Relatedly, to the extent that current students seek out dual training in part because of the career flexibility it provides, it is possible that excellent applicants who prioritize this will not apply. However, given that clinical psychology PhD programmes only accept a tiny proportion of programme applicants each year, it is possible that those who seek PhD training that excludes clinical training will be highly similar to the students we already train, both in number and aptitude. Relatedly, if student numbers are reduced, this could impact clinical faculty members' research programmes, to the extent that faculty recruit PhD students to assist in their research programmes. However, given that these students would no longer spend time on clinical activities in the proposed model, they would have increased time to spend on research, potentially offsetting any decline in the number of students. Further, psychology professors in areas other than clinical psychology have productive research programmes without this resource, so doing so is clearly possible. An additional hazard is that the field could lose prestige if the master's is the primary degree that permits entry into the profession as a psychologist. However, if master's-level psychologists become known for providing evidence-based treatment that puts the welfare of patients front and centre, it could become a highly prestigious occupation.

### Conclusions

Many of the points I raise have been noted elsewhere, either recently (Mikail & Nicholson, 2019) or many decades ago (e.g., Davidson, 1970); however, I contend that, given the global challenges that currently confront humanity, there has never been a more critical time for clinical psychology to change our training approach to better meet the pressing mental health needs of Canadians. Despite the timeliness of this proposal, the notion of abandoning the scientist-practitioner training model is daunting, perhaps because many of us deeply value the training experiences we had under the auspices of scientist-practitioner and similar programmes. Further, many academic clinical psychologists likely regard training graduate students in clinical training programmes as among the most rewarding of career aspects. Scientist-practitioner and similar dual training environments are clearly capable of producing excellent researchers and clinicians; they are just remarkably inefficient ways of doing so.

In this article, I have aimed to provide a useful, albeit broad, overview of a master's-level training model. Readers involved in the training of clinical psychology graduate students will undoubtedly note significant obstacles, hazards, and concerns not touched upon in detail here. This is because designing and implementing the training programme I have described would require the commitment and intellectual contributions of multiple stakeholders; further, significant financial resources would be required. A conference similar to earlier meetings (APA, 1947) focused on training models would likely be needed. However, it is my hope that the ideas proposed here will instigate a conversation among Canadian clinical psychologists who agree that we could apply our commitment to

<sup>3</sup> I am assuming that most readers are familiar with the Association of Psychology Postdoctoral and Internship Centers system; for those who are not, students and residency sites, which are not run or otherwise controlled by clinical training programmes, are matched via computer, and it is not unusual for even very good programmes to have a trainee fail to be matched, necessitating a wait of over a year for another attempt to match. See <https://www.appic.org> for more information.

evidence-based practice fruitfully by training master's-level clinical psychologists to meet the rapidly growing need for effective intervention. In closing, I recall Conway (1984) noting that a potential drawback to CPA initiating its own accreditation system was its potential to "stifle experimentation and new developments in clinical training" (p. 190). Although Conway dismissed this as unlikely, I would argue that an inability to reconsider our approach to training, in the face of compelling evidence that we should, might indicate that this downside has come true.

## Résumé

La psychologie clinique en tant que discipline est loin d'avoir atteint son plein potentiel en ce qui a trait à améliorer le fardeau énorme et sans cesse croissant associé aux troubles mentaux. Cet article donne un aperçu de la manière dont les approches actuelles de la formation en psychologie clinique contribuent à ce déficit. Tout d'abord, un aperçu du développement de la formation en psychologie clinique et du modèle scientifique-praticien aux États-Unis et au Canada est fourni, suivi d'une discussion sur les limites de ce modèle, qui reste l'approche prédominante de la formation doctorale en psychologie clinique au Canada. Une autre approche de la formation clinique est proposée, dans laquelle les psychologues cliniciens prennent l'initiative d'élaborer des programmes d'études fondés sur des données probantes pour la formation appliquée qui est mise en œuvre au niveau de la maîtrise. Dans le cadre de cette approche, la formation doctorale serait réservée aux stagiaires intéressés par la recherche et d'autres aspects pertinents de la science clinique. Cette approche pourrait produire rapidement et efficacement un grand nombre de cliniciens fondés sur des données probantes et créerait potentiellement plus d'emplois pour les titulaires d'un doctorat en psychologie clinique, entre autres avantages importants.

**Mots-clés :** formation clinique, scientifique-praticien, science clinique, universitaire-praticien

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Received September 22, 2023

Revision received February 26, 2024

Accepted February 26, 2024 ■